Journal

OF THE NATIONAL ASSOCIATION
OF CHIROPODISTS

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VOL. 44, NO. 5 MAY, 1954

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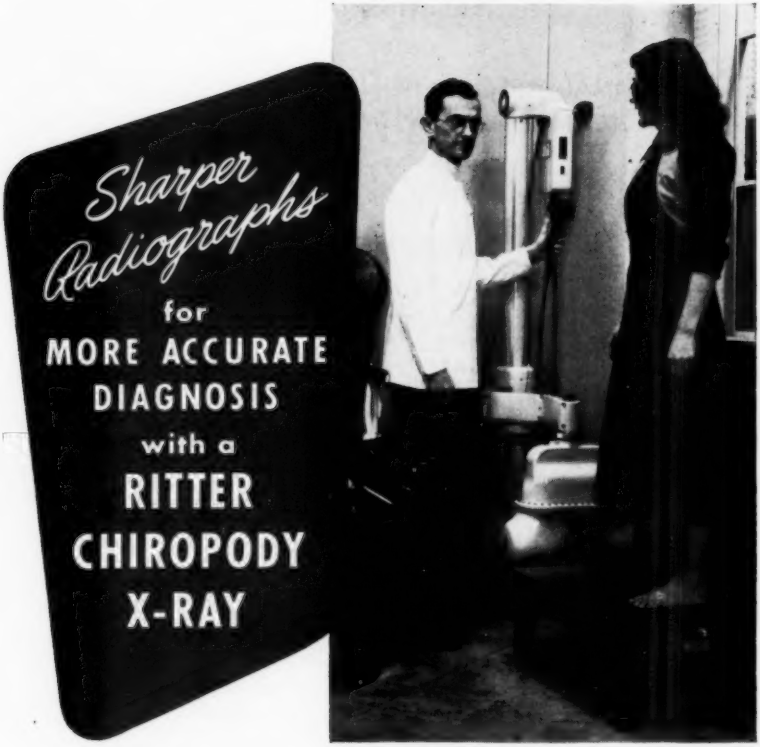

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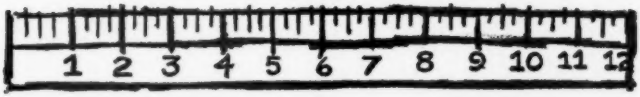

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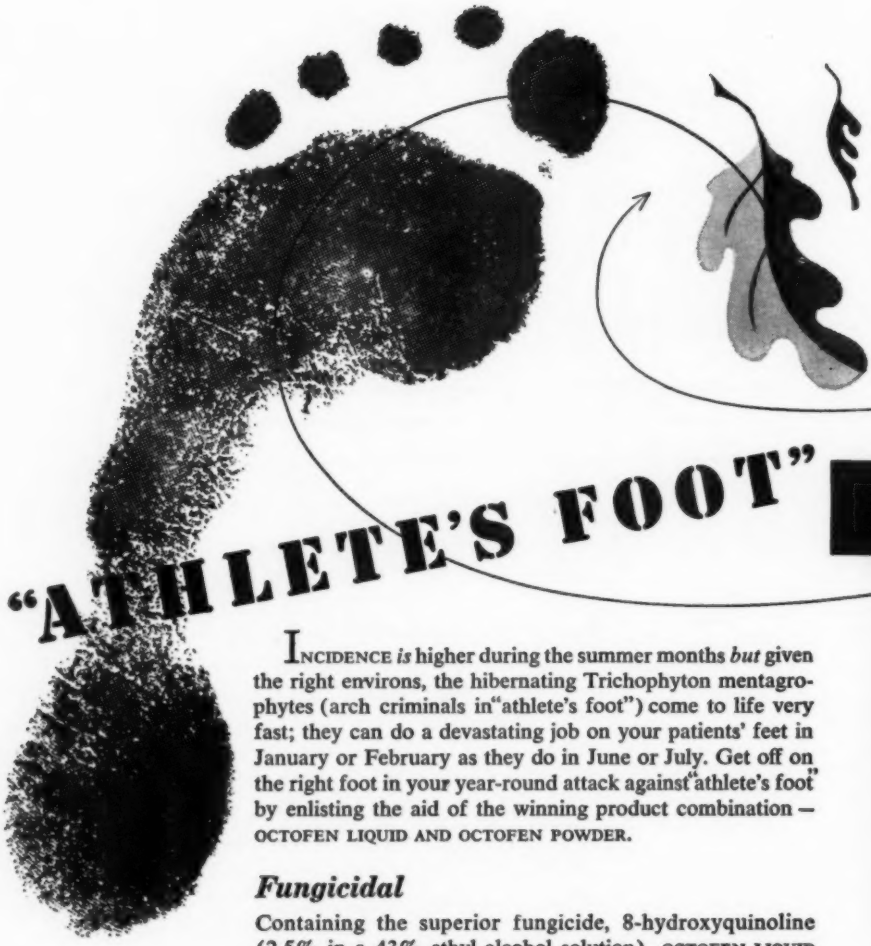

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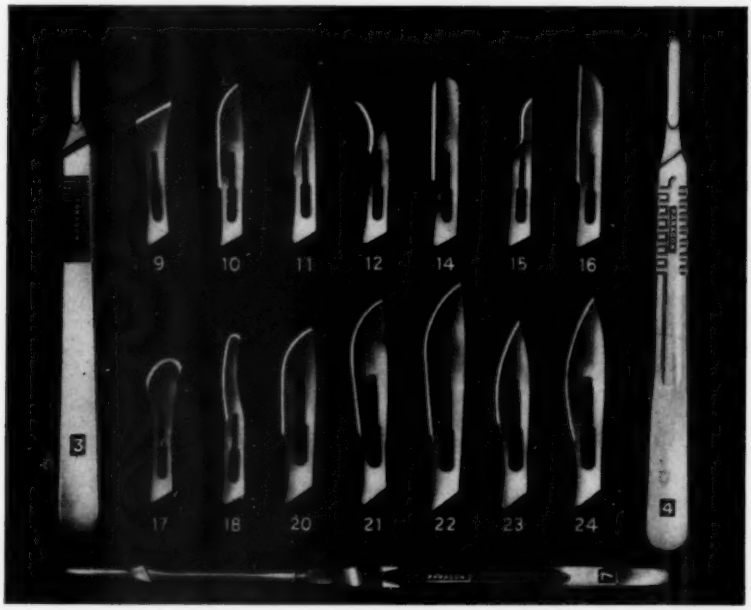

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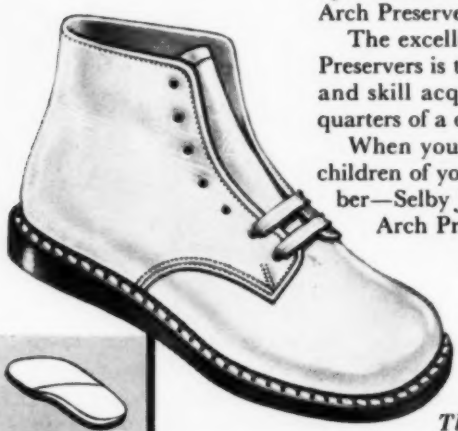

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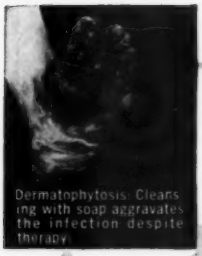

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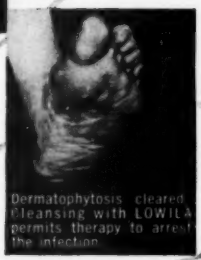

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VOLUME 44 MAY, 1954 NUMBER 5

FOOT SURVEY AT BOYS' SUMMER CAMP — A REPORT

RICHARD S. GILBERT, B.S., Pod.D.
Rockville, Md.

THE purpose of this paper is the presentation of recorded evidence resulting from the study of a survey of a boys' camp in relation to the analysis of clinical foot problems in children. It is the desire to promote a clearer understanding of the basic problems of children's feet, and to impart our impressions on the subject. It is not our intention to go into intimate details concerning foot pathology, but rather, to point up the overall picture of the many problems that exist. In a complicated mechanical system, only a comprehensive picture of all the component parts can lead to a true appreciation of the type and degree of any mechanical deficiency. In the last analysis, a final evaluation of the mechanical system is not based on whether the intrinsic osseo-ligamentous structures are the prime supporters of the foot; or whether this job is relegated chiefly to the extrinsic muscles of the foot. It should be based on the combined kinetic performance of the entire mechanical system.

Foot care and health is still the one problem that has not been investigated in such manner that the general public can fully appreciate its merits. We all know that the great majority of foot complaints stem directly back to our childhood, and our initial introduction to footgear. Upon hearing the views of some practitioners, one could assume that all foot problems are directly related to the well-known pronated foot. We will agree that wedges, metal plates, and various muscle exercises have been used indiscriminately to a great degree. How often have we heard "let us try a Whitman for a while, and if that does not work there is always the inner wedge or balance therapy." Empirical medicine is something that the physician and chiropodist have been using for a long time with more than a fair degree of success. There are many methods of treating diseased conditions that cannot be explained to everyone's satisfaction, yet we know that excellent results can be obtained. To

practice chiropody without thought into the pathology, etiology, and actual need for therapy, is an injustice both to the patient and practitioner. One may now ask the question, "how can two doctors treating the same identical condition with completely different methods achieve a successful termination of the case?" Could it be that many of the conditions will respond to more than one therapy, or actually if left alone will disappear without any treatment being instituted. It is our contention that the basis for proper therapeutics be based not on theory, but on clinical experience. Unfortunately many theories which have become part of us, soon develop into our application of principles, thus our therapy is one of knowledge of theory and we have a tendency to stop looking any further. We are perfectly satisfied to let many of the theories supplant any initiative that we might have had. It should be remembered that *it is just as difficult to accept a single theory without reservation as it is to reject it unconditionally.* Conjectures and theories may be formulated as to their pathogenesis, but the fact is, that our knowledge of children's foot weaknesses is so woefully inadequate that it is difficult to interpret proper therapeutics in terms of cause and effect. An example of this, and of which we will go into more detail later on, is the theory that muscle weakness is the cause of pronation. Wide discussion, debate, and hotly contested arguments have gone into this textbook statement, but apparently unlearning is quite a chore.

It is our thought that some useful inferences can be drawn from this survey. The paper is presented with records and tables showing the results. There was no pre-conceived idea of what was to be found, nor did we have any objective in mind other than to present facts and figures which would stimulate thinking on the subject.

The survey represents an examination of 129 boys, ranging in ages from 5-16. The economic status of each varied from middle class to wealthy.

Technique Used in Examination

1. Each child completely stripped when examined.
2. Examination of feet both from weight bearing and rest attitudes.
3. Examination included observation of foot, leg, knee, hips and spinal column.
4. Observation of footgear.
5. When necessary the Tax method of judging for genu valgum or varus was used.
6. Examination of child from the anterior-posterior view, lateral view, and in the bent over attitude (as described by Kleinberg) to determine if any scoliosis present was of a structural or functional nature.
7. When metal arch supports or other types of appliances were found an attempt was made to find out how long the child had been wearing them, whether prescribed by a physician or chiropodist, and the results if any. In most of the children under 12 years of age the information was obtained from the parents.

Factors Taken Into Consideration

1. Age.
2. Weight.
3. Body type.

4. Foot type—whether flexible, rigid, or flaccid.
5. Genu valgum and genu varus.
6. Toe deformities.
7. Heloma and tyloma as to incidence to certain areas of the foot.
8. Objective weak foot—(can also be called pronation).
9. Subjective weak foot—pronation with subjective complaints.
10. Miscellaneous factors were found and reported—these included some of the rare foot types, scoliosis, verrucae, onychocryptosis, and the osteo-chondritities.

TABLE 1

Number of Boys Showing Pronation

Age Group	Bowing of Tendon Achilles	Objective Weak Foot	Subjective Weak Foot
6-10 (77)	41 (53%)	47 (60%)	1 (1%)
11-16 (52)	21 (40%)	23 (44%)	5 (10%)

It can be seen in Table 1 that in the age group of from 6-10, which comprised 77 boys, 47 or 60% showed pronation. Throughout this entire paper the words pronation and objective weak foot are used interchangeably. By pronation, we mean abduction of the forefoot with calcaneal valgus. In this group of 77 children it is interesting to note that only one child had any subjective foot complaint. This boy was under the care of a physician and was wearing Whitman plates.

In the age group of 11-16, which comprised 52 boys, 23 or 44% were found to have pronation. Here we note that 5 of the boys had subjective complaints varying from pain to just a tired feeling in legs and feet. The composite picture shows that out of the 129 boys examined, 70 or 54% had pronated feet, with only 6 children having any subjective complaints. According to Tax, "the feet of all children pronate from a mild to a severe degree and may be observed as soon as the child bears any weight." In his experience only 20% of children's feet at the age of one year could be characterized as normal. It is our belief that many inherent variables unite to form a structural unit which serves the function of locomotion. The feet, have, therefore, in common with other structures, a range of variation within the classification of normal. To say that a pronated foot is pathological merely by observing the abduction of the forefoot and the calcaneal valgus, without looking deeper into the picture is merely a way to excuse our lack of understanding of the problem. How can one determine whether or not a deviation from the normal position is within the physiological limits of that particular foot? We should consider a joint normal if its range of motion represents the range established for a majority of normal individuals by numerous observations (Steindler). Only 6 children out of 129 had subjective complaints. It would be unscientific to say that the 70 boys who showed objective weak foot only, would develop flatfeet, low back pain, knee complaints, and other postural deformities later on in life. Pronation should be considered a pathological entity only when the examiner feels that it is of a severe degree and accompanied by limitation of motion or pain. Not every pronated foot breaks down into the typical textbook picture. Here is where clinical experience plays such a vital factor. Schuster states that 90% of early toddlers pronate, but that in the later age group of 20-24, when ossification is complete the incidence of prona-

tion decreased from 10-15%. An excellent thought to remember is that there is a tendency for the young to pronate—the older to improve on it. Contention for therapy is based on whether the feet are normally pronated or what is to be considered abnormally pronated. The term "abnormally pronated," is a good and descriptive term, in which much confusion can be prevented. Pronation is normal but under certain circumstances such as limitation of motion and pain can enter the abnormal phase and require treatment. A very slight pronation can cause painful symptoms, whereas a marked pronated foot may be pain free. It should be remembered that pain and eventual breakdown later on in life is not always proportional to the degree of pronation. Other factors enter the picture and have to be evaluated. Consideration should be given to the foot type, whether flexible or rigid, age of person, the family history, general health of the individual, the motions of the foot, whether active or inactive, and to the presence or absence of pain. The 70 children who showed pronation without subjective complaints all had flexible feet. The ranges of motion in the tarsal-metatarsal joints were all normal, the motions in the entire foot were all normal, the feet were all functioning properly—hence the feet were pronated but *normal*.

We would like to discuss the classical textbook statement "that muscle weakness is the cause of pronation." Although this is not a paper on therapy, I feel it is necessary to evaluate the above statement to promote a clearer understanding of pronation. Exercises to strengthen muscles in the hope that this would correct defects in childhood have been advised for more than fifty years without presentation of a sound premise or convincing clinical evidence that it is effective when practiced. We have all seen both adults and children who have pronation and who are dancers or athletes. When this fact is mentioned, the answers usually given are that they are exercising the wrong group of muscles, or that one group is overpowering the other. Both intrinsic and extrinsic muscles with their respective tendons are the essential structures upon which the foot is completely dependent for balance in walking (Schwarz). Of these two, the extrinsic group has the predominant influence. These extrinsic muscles of the leg send to the foot their strong tendons. The gastrocnemius, tibialis anticus and posticus by the very nature of their insertions are the most important. If pronation were due to muscular weakness, it would be these very muscles that would be held responsible. Yet, what better way is there to exercise the above-mentioned muscles than by walking, running, dancing, and participating in all types of athletics. However, "the prevailing balance in the efficiency of normal muscle function determines the presence or absence of balance in the foot as related to pronation and associated functional strain (Schwarz)." That is why we cannot completely divorce the importance of proper muscular function and power. It is necessary for proper balance function of the foot, and in turn the entire body. It does not support the arch or have any factor in pronation other than aggravating the condition by disturbing balance efficiency. "Pronation will prevail in childhood whenever the functional characteristics of skeletal structures favors its presence, even though the extrinsic muscles of the feet are normal in strength and function (Schwarz)." "The axis of weight bearing of the os calcis is displaced laterally from 1-1.5 cm. to that of the tibia (Schwarz)." This malalignment is considered normal at the present time despite the

fact that it favors instability of the foot on the medial side. Perhaps the evolutionary picture will change in the next few hundred years so that the weight bearing line or axis of the os calcis will fall directly below the weight bearing line of the tibia. The presence or absence of pronation is primarily dependent upon the maintenance of a parallel between the axis of weight bearing of the os calcis and that of the tibia. When this parallel alignment takes place there is a lock in the calcaneo-cuboid joint which prevents pronation. "Under the influence of body weight, if the parallel alignment is upset, the os calcis rotates into valgus, the talus sinks into position, and the foot presents the characteristics of pronation—hence the position of abduction of the forefoot with valgus position of the os calcis (Schwarz)." How do we explain the fact that 30% of the children showed no signs of pronation? This is a rather high percentage as compared to what Tax has found. It can be explained when we consider the inherent characteristics of the osteo-articular structures independent of muscle strength. "The presence or absence of pronation is primarily dependent upon the inherent characteristics of the intrinsic osteo-articular structures of the foot and their relationship to the tibia in stance (Schwarz)." The very small percentage of humans who are fortunate to have this parallel alignment of tibia and os calcis on weight bearing show no signs of pronation.

Pronation is not to be considered a pathological entity, nor is it to be considered a normal process at all times. It can cause pain and adverse symptoms later on in life. It is the degree of pronation, amount of pain, flexibility and other factors mentioned previously that we should consider, our clinical experience and judgment; then and only then can we classify it as abnormal pronation and approach the problem as a definite clinical entity amenable to therapy.

TABLE 2

Relationship of Age, Weight, Body Type and Foot Type to the 6 Boys with Subjective Weak Foot Complaints

Age	Weight	Body Type	Foot Type	Other Factors
10	92	average	flexible	wore Whitman plate 3 years
11	94	average	flexible	tyloma first toe joint, genu valgum
13	130	overweight	flaccid	cookies in longitudinal arch—2 years
14	102	average	flaccid	tyloma first toe joint and first metatarsal head, heloma durum 2nd, 3rd, 4th toes
15	135	average	flexible	wore Whitman plate 4 years, genu valgum, tyloma first toe joint-medial
15	135	overweight	flexible	onychocryptosis, tyloma, plantar first metatarsal head

(Body type classified as underweight, average, and overweight)

Table 2 presents a breakdown of the 6 boys who complained of pain. Two were under the care of physicians and were wearing Whitman plates. Another had rubber cookies placed in the longitudinal area of the shoe, also under a physician's care. It is rather significant that in the above six cases, none was under the care of a chiropodist. Five of the six boys were classified as having abnormal pronated feet, the pain being a result of extensive strain on the ligamentous and soft tissue structures,

resulting in excessive joint tension. It is inadvisable to labor under the impression that these pains would be outgrown. A painful foot should be treated at all times with the hope of preventing further foot pathology and removing the existent pain. In some cases, the pain is not proportional to the degree of pronation, yet is very painful. Age, weight, general health, foot flexibility, inherent factors all play an important part in the etiology. Two of the boys who had painful feet had flaccid feet, thus making the parallel alignment of the os calcis and tibia more difficult to control.

"Knock knee is common in young children and is usually associated with, and aggravated by, general relaxation of the ligaments, poor posture and abnormal pronation (Howorth)." It is usually noticed around 2-4 years of age and often the legs tend to straighten with growth. The 6-10 age group showed 44% having genu valgum, whereas the 11-16 age group showed a marked decrease to 26%. As the child grows older the condition should improve. When an improvement is not seen at the age from 11-16, a further investigation should be instituted. "Knock knee is often associated with external torsion of the tibia and is aggravated by external rotation of the femur or anteversion. Knock knee is also aggravated by lying prone with the legs in internal rotation or by sitting with the legs flexed in abduction and external rotation. It also occurs in poliomyelitis when there is a paralysis of the medial hamstrings with a strong biceps (Howorth)." The child with knock knees may complain of fatigue and leg ache with any vigorous use of the legs. "Knock knee of severe degree is rare today and should be considered a surgical problem (Tax)." With the exception of one boy, age 16, who had severe knock knees associated with a postural deformity, the remainder of the boys' knock knees were of a very mild nature. One should be on the lookout for unilateral knock knee caused by damage to the lateral side of the lower femur or upper tibial epiphysis by traumatism or infection. Osteotomy is usually required for correction of this deformity. (See Table 3).

Table 4 shows that the incidence for heloma and tyloma is more than doubled in the age group from 11-16. Why this is so is difficult to say. We know that shoes and hosiery are a vital factor. Hyperidrosis, wrinkled socks, poor fitting shoes, crawling and jumping, and pronation may be

TABLE 3

Relationship of Genu Valgum to Objective Weak Foot

Age Group	Objective Weak Foot	Genu Valgum
6-10 (77)	47 (60%)	13 (44%)
11-16 (52)	23 (44%)	4 (26%)

TABLE 4

Inidence of Heloma and Tyloma and Relationship to Age Group

Age Group	Heloma and Tyloma	Other Toe Deformities
6-10 (77)	20 (30%)	3 (3%)
11-16 (52)	40 (71%)	5 (9%)

blamed. Foot flexibility, weight and inherent factors should be considered also. It should be remembered that all children have sensitive skin and when they grow older, the skin toughens up, and a great majority of the skin excrescences usually disappear.

TABLE 5

Breakdown of Heloma and Tyloma to Each Age Group

Age	Number of Children	Incidence for Heloma and Tyloma
6	8	2 (25%)
7	4	0 (0%)
8	19	2 (15%)
9	15	3 (20%)
10	31	12 (39%)
11	13	12 (92%)
12	13	8 (61%)
13	13	11 (85%)
14	8	7 (87%)
15	5	3 (60%)

The highest incidence (Table 5) is at the age of 11 (92%), with the ages between 12-15 following closely behind. The importance of properly fitted shoes and socks cannot be overemphasized. Shoes can be the cause of deformity without the child complaining of any pain (flexed or hammer toes due to short shoes or a combination of poor fitting shoes with ill fitting hosiery).

TABLE 6

Most Prevalent Site for Heloma and Tyloma	Number	%
1. Medial aspect of great toe and first metatarsal joint.	37	(61%)
2. Plantar of first metatarsal head.	25	(41%)
3. Plantar, lateral aspect of 5th metatarsal-phalangeal joint.	4	(7%)
4. Dorsum of fifth toe.	6	(10%)
5. Dorsum of 2nd, 3rd, and 4th toes.	7	(11%)
6. Plantar of 3rd metatarsal head.	1	
7. Pantar aspect of os calcis.	1	
8. Plantar of 2nd metatarsal head.	1	
9. Pantar of all metatarsal heads and dorsum of all four toes.		

Table 6 reveals some very interesting information. The most classical area for heloma and tyloma is at the inner side of the great toe and first metatarsal joint. 61% of the lesions were found to be at that site. This can be explained by considering the following.

1. Basically it is a shoe problem. The stitching of the upper to the lower in that area is a source of irritation.

2. The toe box causes irritation.

3. Pronation—since most children pronate to some degree, irritation is set up in this area.

4. With pronation, the child drives off in his steps in walking and running with most of the pressure and friction exerted in that area.

5. A rotation of the great toe, rolling underneath at times and assuming the abducted attitude.

6. Shoe bite—this is probably the most prevalent problem that parents have to contend with, especially when buying new shoes.

In Table 7, we see that just as many children had tyloma and heloma without signs of pronation as to those who did. This is a very significant observation as it further emphasizes the fact that footgear is the most basic problem when dealing with skin excrescences. We can see that pronation is not the one vital factor governing all our foot pathology. We would say that about 75% of the footgear examined were poor-fitting shoes. They were either too small and tight in the toe area, had a shoe bite, worn heels, or were generally in poor condition. In certain instances, therefore, the beginning of trouble is directly related to a particular pair of shoes. In feet which present a multiplicity of structural changes and functional limitations, there is evidence of the harm imposed by shoes.

TABLE 7

Relationship of Pronation to Incidence of Heloma and Tyloma

Age Group	Pronation	Heloma and Tyloma	Heloma and Tyloma No Pronation
6-10 (77)	47	9 (21%)	11 (23%)
11-16 (52)	23	18 (78%)	22 (99%)

Other Interesting Foot Findings

1. Verrucae—age 11, multiple plantar verrucae, never treated.
2. Schaffer foot—age 11, following polio attack, clawing of toes, heloma and tyloma present.
3. Pes planus—age 10, familial condition.
4. Pes cavus—age 8, heloma and tyloma present, no clawing of toes.
5. Onychocryptosis—age 16, bilateral, proud flesh, chronic condition.
6. Verruca—age 14, plantar first metatarsal head, never treated.
7. Verruca—age 13, plantar third metatarsal head, treated with electrodessication, recurrence.
8. Osgood-Schlatter's disease – age 14, wore knee support, limited activity.
9. Lumbar scoliosis—age 14, functional basis.
10. Hallux valgus—age 15, full blown picture of hallux valgus, bilateral. Mother and father both have condition.
11. Verruca—age 10, plantar first metatarsal head, painful and treated with carbon dioxide snow before camp season started.
12. Syndactlyism—age 11, bilateral, webbing between second and third toes.
13. Triple arthrodesis operation—age 11, for clubfoot that was initially mismanaged. Foot was fairly stable and child doing nicely.

Comment

There appears to be little doubt that pronation is a normal characteristic trait, occurring in the majority of children and should be differentiated from an abnormal type of pronation which has subjective complaints that can lead to further foot pathology. There is often no clear distinction between what should be considered abnormal pronation or normal pronation. The subjective complaint is not always proportional to the degree of pronation. The distinction between the two depends

upon the individual examiner's clinical ability to correlate a number of factors.

The early recognition of abnormal pronation with prompt and effective treatment is of the utmost importance. The author feels that such a common condition which is often mistreated, over-treated, or not treated when it should be, should be familiar to all chiropodists so that the child may be saved the added discomfort of unnecessary arches, plates of all types, wedges and various exercises.

Until the function of the foot and the requirements best suited to preserving those functions have been thoroughly investigated and evaluated, controversy and debate will prevail. It is through such discussion that progress is made.

Summary

1. 129 boys were examined with pronation being present in 60% of the age group from 6-10, and 44% in the 11-16 group.

2. Only 6 boys had subjective complaints.

3. Pronation in childhood is an expression of an inherent deformity in the function of the intrinsic osteo-articular structures of the foot.

4. Both the presence and absence of pronation are explained briefly on the basis of the functional characteristics of the os calcis, cuboid, and their physical relationship to the talus and tibia. A neutral position of the os calcis does not permit pronation of the forefoot.

5. A pronated foot if functioning properly is a normal foot. Just as many aged people are walking around pain-free with pronated feet, as there are oldsters complaining of pain.

6. The term "abnormal pronation" is introduced by the author to describe a pronated foot that has pain, or if in the opinion of the examiner (after clinically evaluating many factors), is subject to further stress and strain and possible breakdown later on in life.

7. An abnormally pronated foot should receive immediate treatment.

8. Knock knee is common in young children and is associated with pronation. As the child grows older it should improve.

9. 46% showed evidence of heloma and tyloma, with the percentage increasing from 30% to 71% in the older age group.

10. The most frequent site for tyloma was at the inner side of the great toe and first metatarsal joint. (61%)

11. The highest incidence for lesions was between the ages of 11-13.

12. Just as many boys had skin excrescences without showing evidence of pronation, as those who had pronation.

13. Footgear and hosiery are still the basic problem in dealing with heloma and tyloma.

The need for an educational program directed to parents, which emphasizes that (a) proper foot care is essential to good health (b) the chiropodist provides skilled service in this field.

References

References available upon request to the author.

303 No. Adams St.

PROLONGED LOCAL ANESTHESIA IN CHIROPODY

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THE need for more adequate pain control measures following surgery, manipulation, and other therapeutic procedures has always constituted a perplexing problem for the podiatrist. The effects of procaine hydrochloride and other agents used to induce surgical anesthesia are too short-lived to play a significant role in the control of postoperative pain. Narcotics and sedatives are commonly employed toward this end, but the dangers inherent in much medication need no elaboration. Opiates, barbiturates, and other sedatives are especially hazardous to children, and to aged and debilitated patients who react atypically to such drugs.

Recent reports (1-8) of prolonged postoperative pain control (6-12 days) obtained with Efocaine* suggested the application of this agent to the relief of pain following chiropodical procedures.

This product is a clear solution of procaine base and butylamino benzoate in a specially balanced, non-toxic (9-12), aqueous miscible solvent. The character of the solution is such that when it is injected into the tissues, contact with body fluids (serum, lymph or extracellular fluid) causes immediate and complete precipitation of the anesthetic bases as an *in situ* crystalline depot. The low solubility of the anesthetic bases thus deposited delays absorption and so extends the duration of anesthesia.

A histopathologic investigation (13) has revealed that the solution does not cause a foreign body reaction, inflammatory tissue reaction, encapsulation, or neurodegeneration. There is complete absorption of the crystalline depot from the site of injection.

Our experiences with the product used in this series have shown it to be a valuable agent for the control of postoperative pain in the ambulatory patient. Through its use, the need for narcotic or sedative medication is virtually eliminated, and special nursing care is minimized. In addition, normal daily activities can be resumed at an earlier time—an aspect of economic importance to most patients.

Injection Technique

Prolonged anesthesia solutions should be restricted to postoperative pain control, and should not be used as the surgical anesthetic. The motor-nerve block often necessary to induce proper surgical relaxation makes it preferable to use the shorter-acting aqueous anesthetics for this purpose. The prolonged motor-nerve block which efocaine would cause is usually undesirable.

The drug is injected through a short (¾" to 1¼") 22 or 23 gauge needle, usually at the conclusion of surgery. However, if the anatomy involved or the extent of surgery makes it desirable, the drug may be injected at the start. Under certain circumstances nerve block may be preferable. If the patient is not under the control of a surgical anesthetic a skin-wheal should be raised, prior to prolonged anesthesia injection, with aqueous procaine hydrochloride, and the immediate subjacent tissues infiltrated with a small amount of the same solution. One or two

*E. Fougera and Company, Inc., New York City.

cc. are usually sufficient for both these procedures. The needle for long lasting anesthesia injection is then inserted through the skin-wheal, and the drug is slowly and continuously injected during withdrawal toward the skin surface. The needle is not completely withdrawn, but is re-inserted in a different direction, and injection is repeated as before. In this manner, a series of fine anesthetic lines are deposited about the wound. The number of such lines necessary for optimal effect will vary with the area to be anesthetized and the innervation of that area. One or two anesthetic lines are sufficient for pain control following most minor surgical procedures encountered in chiropody. The dose of the solution required will vary with the particular use involved, but ½ to 2 cc. will generally suffice.

Technique for Toe Block

(See Fig. 1) Special caution must be exercised in injecting the anesthetic about the toes. The soft tissues in these regions are thin, and a tendency to overdosage and superficial placement exists. Here the preferred injection technique is the creation of a nerve block in the metatarsal or tarsal area. An intradermal wheal is raised with aqueous procaine hydrochloride solution on each side of the mid-point at the dorsal medial border of the foot, alongside the metatarsal bone (for the great toe), or at the indicated intertarsal space (for the toes). Another intradermal wheal is raised at each web on either side of the toe (or toes),

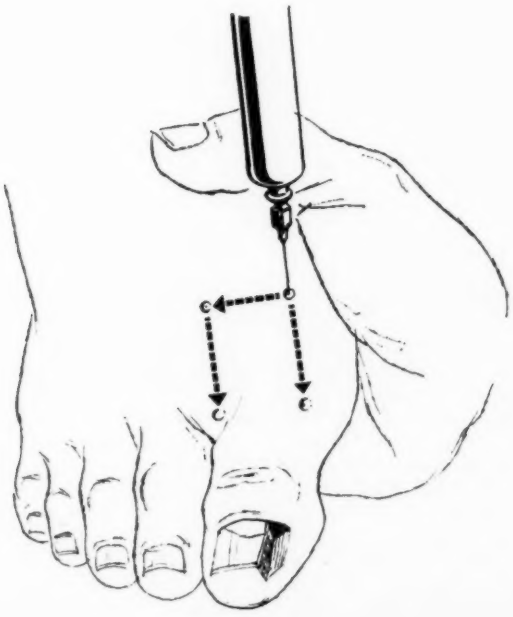

Fig. 1

and one at the extremity of each intertarsal space, on either side. In the case of the great toe, the dorsal medial border of the foot alongside the metatarsal bone is utilized. Inject the solution through the proximal wheals in a fan-wise manner into the interosseous space. Keep the hand beneath the sole of the foot in order to feel the needle as it advances. Through the distal wheals, incline the needle toward the median saggital plane of the metatarsal bone and inject against in a fan-wise manner down the plantar surface of the bone. Do not pool the drug in any of these procedures, being absolutely certain that the drug is placed entirely in the deeper subcutaneous and intramuscular tissue. Do not inject intra-articularly.

Injection Technique for Ankle Sprain

(See Fig. 2) Simple sprains of the ankle respond most dramatically to injections of local anesthetic solutions. The possibility of fractures must be eliminated in all instances by the conventional means of roentgenologic diagnosis. The local anesthetic solution is injected about the sprained area in a fan-wise manner in order to completely block all pain sensations. All indicated therapeutic procedures, such as strapping, etc., should also be carried out. The effects of the pain control are immediate and the patient will usually be able to resume his normal functions on leaving the office.

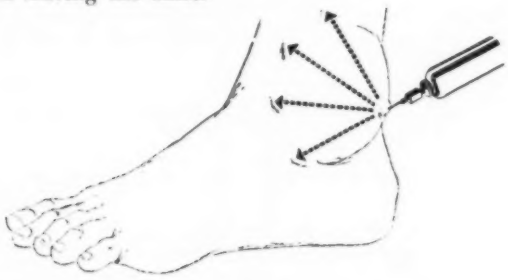

Fig. 2

The technique of injection for a sprained ankle is as follows:

With procaine hydrochloride raise a skin-wheal on the ankle proximal to the origin of the swelling, and also inject some of this solution into the sprained area. This will serve to anesthetize the tissue and give the patient maximum comfort during further manipulation and injection. Approximately 2 to 3 cc. of procaine hydrochloride solution are sufficient for both the creation of the skin-wheal and the anesthetizing of the sprained area. After a few minutes, the prolonged anesthetic is injected through the skin-wheal and into the strained area in a fan-wise manner. The needle is inserted through the edematous tissue, and the solution is injected slowly as the needle is withdrawn. Without removing the needle, it is re-inserted in another direction and injection is repeated as before. By repeating this procedure, a series of fine anesthetic lines is created. In the case of bilateral sprains, this infiltration may be carried out on both sides. It is important to include in the infiltration all of the tender areas which may be located by gentle palpation. Avoid superficial injection and injecting the solution into a hematoma. Aspiration should be

carried out frequently to avoid the possibility of an intravascular injection and a consequent prolonged blood ooze. In most cases, about 2 cc. of efocaine are sufficient to control the pain arising from sprained ankles.

Injection Technique for Morton's Neuralgia

(See Fig. 3) A lesion often seen by chiropodists is Morton's neuralgia. Here we are dealing with a patient who has exquisite pain. The introduction of 1 cc. to 1½ cc. of a prolonged anesthetic solution on either side of the impinged nerve brings long-lasting relief and the most effusive gratitude from the patient. Of course, the obvious causative factors such as tight shoes, depressed anterior metatarsal arch, etc., must be removed and treated in the usual manner.

Fig. 3

Several precautions should be observed when using the product mentioned in our experiments:

1. To preclude the possibility of intravascular injection, aspiration should be performed prior to injection. If blood is aspirated into the syringe, the needle should be withdrawn and gentle pressure applied for one or two minutes. The needle should then be re-inserted in another direction to complete injection.

2. Pooling the drug or overloading the tissue with it must be carefully avoided. Keeping the needle in constant motion while slowly injecting only enough drug for optimal effect will assist importantly toward this end. When copious quantities of aqueous anesthetic solution are used as the surgical anesthetic, some time should elapse before the prolonged anesthetic is injected. Injection of a solution containing propylene glycol into tissue already "waterlogged" with an aqueous solution causes a too-rapid precipitation and a conglomeration of the anesthetic bases. Pooling will result. Small quantities (2 to 3 cc.) of aqueous anesthetic

are absorbed sufficiently by the time surgery is completed to minimize their effects on the precipitation rate of this product.

3. The long-lasting anesthetic should be injected only intramuscularly as subcutaneously. Intradermal or too superficial injection must be avoided. The appearance of a bleb or a bulging indicates that improper injection has occurred. Plunger pressure should be stopped completely as the superficial tissues are approached during withdrawal of the needle.

4. This solution must not be injected intra-articularly.

5. Infected or deranged tissue must not be injected with any long-lasting anesthetic. However, the drug can be injected outside the infected area so as to interrupt the pain stimuli emanating from the lesion.

6. Injections into tight compartments should be avoided, for the principle solvent of this product is hypertonic and will abstract tissue fluid. This abstraction of tissue fluid into a tight compartment will result in a pressure which may lead to necrosis. Utilizing small dosage and carefully avoiding tight compartments by substituting a nerve block will eliminate this problem.

7. The same aseptic technique should be observed during use of efocaine as during any other injectional procedure. Particular care in this regard should be observed if, as is frequently necessary in practice, an infected area has been opened previously to injection of the anesthetic.

The precautions against pooling, and superficial and intra-articular injection are necessary because as mentioned above, the anesthetic bases of the product we used are deposited *in situ* in crystalline form. It is this fact which makes necessary the precautions against pooling, and superficial and intra-articular injections. In such cases, the crystalline material will mechanically grate upon the surrounding tissue, and irritation, erosion, or sloughing might occur. When it is injected properly, subcutaneously or intramuscularly, a sufficient "cushion" of tissue surrounds the crystalline depot and no untoward reaction occurs.

Discussion

A valid criticism of the use of anesthetic pain control procedures is that complications might be covered up because of the absence of pain. This factor should be recognized and met by adequate follow-up regimens. No surgeon is so self-confident that he will not require his patient to return for a postoperative examination. It is recognized that under certain conditions postoperative visits are difficult, if not impossible, to obtain because of a patient's uncooperative attitude. Where these situations can be anticipated, postoperative pain relief by means of local anesthetics should not be used. In fact, one wonders whether surgery should be carried out under these conditions. No drug is ever to be used routinely without giving consideration to the patient's needs and the particular problems at hand. It is, of course, recognized that every patient presents his own particular problem because of his individual pathology, anatomy, and over-all doctor-patient relationship.

The problem of pain-control's masking surgical complications seems of no real concern when we investigate the application of prolonged anesthesia in other fields of surgery. In studies reported in the medical literature, and dealing with more than a thousand patients treated with the product that was used in our work, this question is not raised, and apparently is of no concern to the general surgeon.

Another question which may be asked concerns the formation of a stitch-abscess as a result of using a prolonged anesthetic agent. Such apprehension is based upon early experiences with the anesthetic-in-oil preparations which, we should remember, cause foreign body giant-cell reactions and acute inflammatory responses. The solution we suggest, because of its aqueous miscibility, has been shown to be histopathologically benign—it will not cause a foreign body giant-cell reaction, nor an acute inflammatory tissue response when properly used. If misused (placed superficially, pooled or if the tissues are overloaded with the drug) necrosis may ensue. However, this is a limitation of technique and not of the drug.

Infected stitch-abscesses arising after a surgical procedure bear no relationship to the drug injected, but rather can be attributed to the character of surgery performed. Efocaine is a sterile solution and does not interfere with the processes of wound repair. With the advent of modern antiseptic agents, stitch-abscesses may be eliminated in the course of surgery. Their occurrence arises from external contamination which may be controlled to a fairly high degree by the good operator.

Results and Conclusions

A summary of the results obtained with this product under the usual conditions of office practice is given in Table I. Pain relief was reported by most patients. The duration of anesthesia ranged from 2 to 3 days up to 10 to 12 days. Inasmuch as infiltration procedures were used in most instances this wide range must be expected. In this series, pain control was excellent in 80.6 per cent of the group, good in 11.3 per cent, and poor in 8.1 per cent. No local or systemic toxic reactions were observed, nor were any sloughs, acute inflammatory reactions nor gross tissue necrosis. No drug will act in the same manner on all patients and, of course, is not expected to. The gratifying results obtained, and the degree of pain relief afforded the patients, make this agent an extremely

TABLE I

POSTOPERATIVE PAIN CONTROL WITH EFOCAINE IN CHIROPODY — SUMMARY OF RESULTS

Indication	No. of Cases	Technique Used	Dosage Used (cc)	Degree of Pain Relief		
				Excellent	Good	Poor
Verrucae	20	Infiltration	½ to 1	17	1	2
Nail Resection	18	Infiltration and Nerve Block	½ to 1	13	3	2
Morton's Neuralgia	10	Infiltration	½ to 1½	10	0	0
Excision of Bursae (Hallux Valgus)	2	Infiltration	1	1	1	0
Adventitious Bursae*	2	Infiltration	1	2	0	0
Trauma**	1	Infiltration	2	1	0	0
Sprained Ankle	5	Infiltration	1 to 2	3	1	1
Sub-ungual Exostoses	4	Infiltration	1	3	1	0
	62			50 (80.5%)	7 (11.3%)	5 (8.1%)

*After previous chemical removal of verrucae.

**Patient had extensive laceration of distal phalanx, nail and nail bed of great toe.

valuable adjunct to surgery and injectional therapy of the foot. Eradication of pain, and rapid ambulation foster well-being, and usually result in a more cooperative patient-doctor relationship. The patient's outlook and morale are stimulated by what is often the first relief in an extended period of discomfort, pain and disability.

The judicious use of prolonged anesthesia for routine pain control in our specialty will do much to obtain patient cooperation and acceptance of difficult regimens, and will afford a higher degree of flexibility to office surgery.

A safe, efficient and relatively comfortable means of pain control may be achieved by observing the cautions noted, and utilizing reasonable care in carrying out the necessary procedures.

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Keith Theatre Bldg.

PARTICIPATE IN YOUR

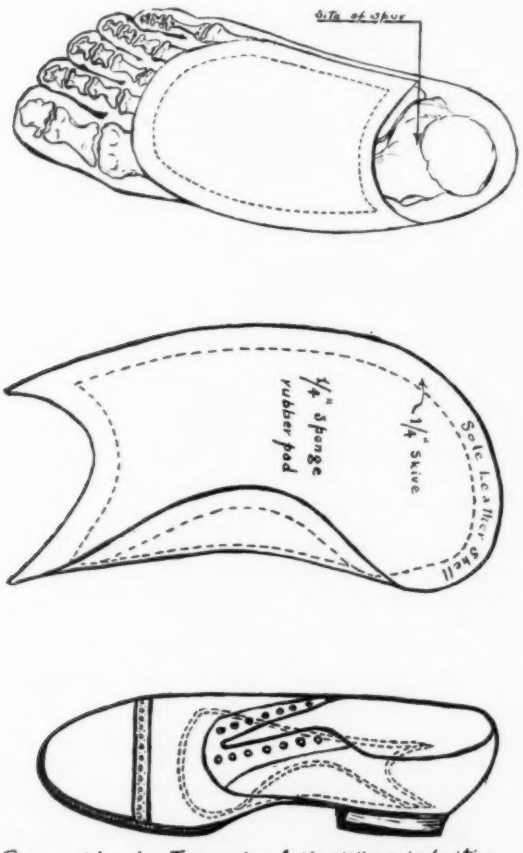
STATE AND LOCAL

CIVIL DEFENSE PROGRAM

AN EFFECTIVE APPLIANCE FOR CALCANEAL SPUR

FRANK J. CARLETON, SR., D.S.C.
West Chester, Pa.

In the diagnosis of calcaneal spur as the cause of heel pain localized inferiorly to the tuberosity of the calcaneus, there are two types now generally recognized. By far the most common of these types is that of a primary excitation of fibrous connective tissue in the attachment of the plantar muscles to the calcaneal tuberosity. This fibrous connective tissue is followed by ossification in the same lines of strain which started the genetic chain and in place of the lines of force in the original strain, the infiltration of the aponeurosis by calcarious deposits creates the



Placement in shoe. Foot contour holds appliance in position.

"spur" of painful result. Since the calcarious growth follows the lines of strain, it extends anteriorly and on the plane of the tendonous attachment.

Less common, but a more generally pictured growth, is the inferiorly directed spur of dense and well defined outline protruding downward from the tuberosity of the calcaneus into the soft tissues.

In either type, the unsatisfactory and sometimes crippling results of surgery rules out this mode of treatment.

The conventional aperture pad of felt, sponge or foam rubber placed in the heel seat of the shoe may give a modicum of relief to the inferiorly directed spur but is of no benefit to the anteriorly directed, tendon infiltrated, calcarious growth.

The simple appliance illustrated is designed to distribute weight bearing evenly to the structures anterior to the calcaneus and just posterior to the metatarsal heads, leaving the tuberosity of the calcaneus and its attachments with a minimum of weight bearing and strain.

Basically the shell of sole leather is of Shaffer outline with the entire heel area cut out. Following the outline of this shell and ¼ inch in from its edge a layer of ¼ inch sponge rubber with skived edge is applied on top. A calfskin top cover and bottom suede completes a calcaneal spur appliance that has proven remarkably effective.

129 N. High St.

PROTECTIVE BALLET TOE PAD

GUSTAVE APPEL, D.S.C.
New York, N. Y.

EACH of us at some time during practice has had a special problem with the feet of dancers. This article deals with the particular problem of the ballet dancer when "on point" or with all the body weight balanced on the toes of one foot only. "On point" being an unnatural position, creates great stress and strain on the toes, long arch, ankle, leg and spine and results in pain in the foot and leg and general fatigue throughout the entire skeletal system, including foot deformities such as hallux valgus, hammer toes, bursitis, distal corns, and weakened arch structure.

With an estimated one million children now studying ballet in schools in this country, it can readily be seen that the problem can become one of great significance.

The average ballet slipper is constructed of flexible materials with a hard toe box. It is in this toe box section where most foot problems originate. To overcome the disagreeable effects of dancing in such a shoe when "on point," most dancers will pad the toe portion with lambs wool, cotton, flannel, wool, a soft powder puff, or paper tissue. Though these help to some extent, they create secondary problems as all tend to lump or bunch-up after a short period of use. This situation has led to the construction of a protective pad that can be fabricated in the practitioner's office and which eliminates the unsatisfactory effects of the aforementioned materials.

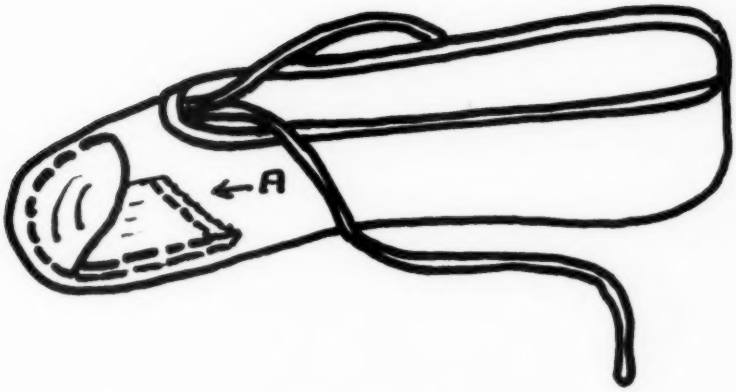


Fig. 1 — The ballet shoe
(a) Position of pad in shoe

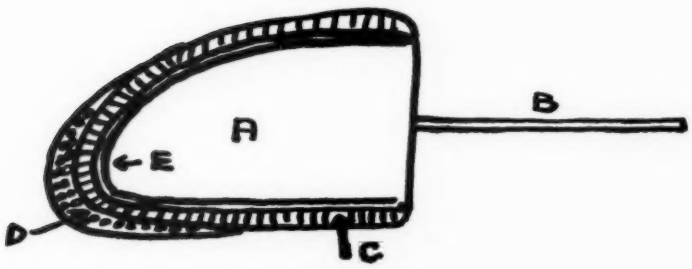


Fig. 2

(a) Plaster impression of inside of shoe (toebox)
(b) Handle
(c) Latex after several dippings
(d) Felt covering

Making the Pad

A plaster impression of the toe portion of the dancer's ballet slipper (Fig. 1) is made (Fig. 2). This "negative" is given several dippings in liquid latex, thus producing an exact image of the entire inner toe portion of the slipper in rubber. After setting till firm the latex coat is removed from the plaster negative. We then cover the anterior-inferior portion of the rubber replica with a thin layer of foam rubber. The posterior portion in turn is covered with a thin layer of felt to do away with any irritation which may result from contact with the rubber, and helps to absorb perspiration.

The pad is then trimmed with the sides cut away so that it will come in contact with the ends of toes, only when "on point," a small portion (lip) being left on the bottom which can be placed under the front of the sock lining of the shoe, to keep the pad in place and not allow any slipping.

Such pads have been in use now for over a year by both professionals and students and have proved satisfactory in every respect.

Fig. 3 — Horizontal section of pad
(a) Latex
(b) Form
(c) Felt
(d) Lip
(e) Sock lining

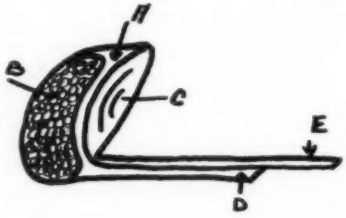


Fig. 4 — The finished pad
(a) Sides cut away
(b) Lip (fits under sock lining)
(c) Sock lining

Summary

A shock absorbing pad is described which will eliminate some of the unpleasantness experienced in ballet dancing. The pad relieves discomfort, curtails deformity, and allows the dancer to "feel the floor." It has also demonstrated that ballet students progress more rapidly and will practice and continue lessons over longer periods as some of the disagreeable hardships of this type of dancing are minimized. Such pads can be made by the chiropodist.

515 W. 110th St.

BE YOURSELF

TODAY we come across a person and find that he acts and feels like an automaton; that he never experiences anything which is really his; that he experiences himself entirely as the person he thinks he is supposed to be; that smiles have replaced laughter, meaningless chatter replaced communicative speech; dulled despair has taken the place of genuine pain.

Erich Fromm.

PROPOSED AMENDMENTS TO THE CONSTITUTION AND BY-LAWS OF THE NATIONAL ASSOCIATION OF CHIROPODISTS

Constitution—Article IV—House of Delegates

Paragraph 2—insert the following between the second and third sentences: *"Representation at the House of Delegates of the National Association of Chiropodists shall be allocated on the basis of the number of paid up members as of the close of the fiscal year prior to the House of Delegates meeting."*

Submitted by
The Podiatry Society of the State of New York

Constitution—Article IV—House of Delegates

Paragraph 3, line 2—after the word "standing" add the following, *"whose current dues in the National Association of Chiropodists are paid."*

Submitted by
The Missouri Association of Chiropodists

By-Laws—Chapter III—House of Delegates

Section 1a (strike out the period and add the following) *"and his membership card showing that his current dues in the National Association of Chiropodists are paid."*

Submitted by
The Missouri Association of Chiropodists

By-Laws—Chapter VII—Committees

Section 4—Duties of Committees—Education (f)—paragraph 3, after the word "chairman" add the following "and vice chairman."

Submitted by
The Ohio Chiropodists Association

By-Laws—Chapter VII—Committees

Section 4—Education (f)—paragraph 3: add at end of the paragraph—"The President of this Association shall appoint an acting chairman and/or vice chairman if for any reason such duly elected officials are unable to fulfill their duties."

Submitted by
The Ohio Chiropodists Association

URGE NON-MEMBERS TO JOIN THE N.A.C.

JOURNAL

OF THE

NATIONAL ASSOCIATION of CHIROPODISTS

PUBLISHED UNDER THE DIRECTION OF THE COUNCIL
BY THE NATIONAL ASSOCIATION OF CHIROPODISTS

DR. WILLIAM J. STICKEL, *Editor*

3500 FOURTEENTH STREET, N. W.
WASHINGTON 10, D. C.

Address all communications intended for publication, matter relating to advertising, business or subscriptions to the Editor.

OFFICIAL NOTICE — ANNUAL MEETING NATIONAL ASSOCIATION OF CHIROPODISTS

To Affiliated State Societies and Specialty Organizations

Announcement

In compliance with Article VI, Section 2 of the Constitution and By-Laws, you are hereby notified that the Annual Convention of the National Association of Chiropodists and Annual Session of the House of Delegates will be held at the time and place indicated on this announcement for the purpose of receiving reports of officers and committees, for the annual election of officers, for action upon regularly offered amendments to the Constitution and By-Laws and for such other business which may be presented.

Time and Place

FORTY-SECOND ANNUAL CONVENTION
Thirty-Fifth Annual Session of House of Delegates
Drake Hotel, Chicago, Ill.
August 12-17, 1954

First session will begin 9:00 A.M. on Friday, August 13, 1954

Authorization

In accordance with instructions issued by the House of Delegates at the last official session, the Council has authorized that the scheduled meeting be convened at the time and place indicated above.

Representation

Article IV of the Constitution provides that affiliated state societies be represented in the House of Delegates in the ratio of one delegate for each one hundred members or fraction thereof whose annual per capita assessment is forwarded to the Executive Secretary on or before July fifteenth of each year.

Credentials

The authority of each delegate or alternate shall be evidenced by a certificate signed by the president and secretary of the affiliated state society. The Executive Secretary of the N.A.C. will forward these certificates to state society secretaries at a later date. State secretaries shall then send them to the designated representatives. Credential Certificates must be presented in person to the Credentials Committee at the time and place of the meeting set forth in this announcement. No delegate or alternate will be seated until his credentials have been approved by the Committee.

Registration

Each person, whether or not a member, sixteen years of age or over, attending the convention, shall register and pay a registration fee, set by the House of Delegates, in U. S. currency, and admission to meetings, clinics, lectures, and all other convention activities will be refused to those not so registered.

Invitation to Members

A cordial invitation is extended to all members. Each affiliated state society is urged to send as large a delegation as possible in addition to the accredited representatives of the House of Delegates.

Resolutions

Proposed resolutions intended for submission to the House of Delegates should be in the hands of the Executive Secretary on or before June 15th.

Signed, Dr. Stewart E. Reed, President

Dated May 1, 1954
Attest: Dr. William J. Stickel, Executive Secretary

SPECIALISTS' OBLIGATIONS DIFFER FROM GENERAL PRACTITIONERS'

THE OBLIGATIONS of general practitioners differ from those of specialists in that the general practitioner need only meet the standard of average medical (or dental) care provided in his community or in similar communities by other general practitioners. On the other hand, the specialist must conform to the treatment accepted as a standard throughout the country by physicians practicing the particular specialty concerned. Any physician (or dentist) can, legally, practice as a specialist regardless of the extent of his training and knowledge. By doing so, he must bring to the care of his patient "that degree of skill and knowledge which ordinarily is possessed by physicians who devote special attention and study to the disease, its diagnosis and treatment; having regard to the present state of scientific knowledge." In other words, the specialist assumes the risk of the designation in return for its rewards.

W. W. Jetter, M.D., The Medical Clinics of North America, W. B. Saunders, Philadelphia.

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References:

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(2) Shaw, H. C.: Navy Dept., Bur. Med. & Surg., Research Div. Final Report, Research Project X-448-A.

(3) Sullivan, M., and Fishbein, H. A.: J. Invest. Dermat., 10, 293-299.

(4) Hopkins, J. G., et al.: J. Invest. Dermat., 7, 239-253.

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THE N.A.C. VISUAL EDUCATION PROGRAM

THE Chairman of your Visual Education makes periodic reports to the membership regarding the work of his committee. Again, we wish to re-state the purposes and functions of the N.A.C. visual education program. The essential purpose of our committee is to develop and distribute various types of professional, ethical and dignified visual aids. Many practitioners have used and are using slides and films which, in our opinion, tend to misinform rather than inform the public. We emphasize in our committee work that chiropodists are ancillary practitioners to medicine, who strive with the physician in maintaining the general health and the foot health of the public.

When chiropodists use unsuitable material that stresses the features of certain types of footwear or includes in his therapy manipulative procedures on the body far removed from the feet, such practitioners are not portraying a true concept of our professional field to the public. It is the responsibility of this committee to provide the types of visual aids which truly describe our practice in keeping with the ethical standards laid down by the National Association of Chiropodists.

We take this opportunity to list some of the aids now available. We can provide films and slides for use by the chiropodist for showing to the public. We also have material which can be shown to physicians and other professional personnel, exhibits for use at state and county fairs, conventions, parent teachers meetings, etc. Regrettably, we do not have these materials in sufficient quantity to provide them for use in many localities simultaneously. However, we will provide diagrams, plans and the know-how for assisting an individual or chiropody group to make satisfactory exhibits and films. The list included here offers ample evidence that the Visual Education Committee is aware of our needs.
Note: All available material will be loaned without charge—postage or express must be paid by the borrower. Most types of material may be purchased on special order. Checks should accompany the order—made payable to the National Association of Chiropodists and sent to Dr. William J. Stickel, Executive Secretary, 3500 14th St., N.W., Washington 10, D. C.

A—List of Material

Individual Slides—in any quantity—50c each.

Color Film Strip—35mm—series of 40 slides, all on one strip—with 33-1/3 RPM, recording and script with full instructions—$35.00.

Portable Exhibit—80″ wide, 40″ high—folds into 4 twenty-inch sections—contains 24 color 4″x5″ prints, photo mural, excellent display, many other features, shipping weight 12 lbs.—$70.00.

Large Exhibit—On loan for Fairs, Health Museums, etc., 16 feet long, 10 feet high, shipping weight 800 lbs.—must be booked 6 months in advance.

Television Film—"The Foot and its Problems" (loaned without charge) for television or regular showing, 24 minutes, 800 feet, sound—16mm, B & W motion picture. This film should be introduced by a chiropodist or physician speaking for about 2 minutes. Following the showing, a 1 minute concluding talk is made. This will require an approximate total of 28 minutes allowing for station breaks. From

30 to 60 days' notice must be given in order to obtain this film. It may be purchased for $135.00.

* * * * *

B—Black and White Motion Pictures— (16mm silent)

1. Minor Surgery in Podiatry
2. Making of Plaster of Paris Casts
3. Shielding in Podiatry
4. Infiltration and Conduction Anesthesia
5. Manipulative Therapy
6. Brushable Rubber (2 reels)
7. Reflexes (3 reels) (Columbia University)
8. Muscle Status (2 reels) (Columbia University)
9. Disorders of Gait (3 reels) (Columbia University)

C—Color Films and Slides

1. Nail Disorders—70 slides—35mm 2″x2″ with 3½″ tape recording —Dr. C. Krausz
2. Electro-Surgical-Correction-Nail Surgery—16mm—Dr. R. Locke
3. Varicose Veins—Diagnosis and Treatment—sound slide film—35mm 2″x2″ with 3½″ tape recording—Dr. M. Shapiro
4. Tumor of the Ankle
5. No. 1 Bunion Surgery
6. No. 2 Bunion Surgery
7. Tumor of Plantar Soft Tissue
8. Bunion Surgery—New Technique—Drs. J. Millis—M. Shapiro
9. Toe Amputation
10. Radical Nail Surgery
11. On Your Toes— (8mm 200 feet motion picture)
12. Library of Miscellaneous Colored Slides (approximately 1,000)
13. Miscellaneous—Black and White Display Prints, 5″x7″ and 8″x10″

D—Individual Color Slides— (35mm 2″x2″)

1. Ingrown Toe Nails
2. The Common Corn
3. Infected Corn—Neglected—Diabetic
4. Soft Corn
5. Pronation—Imbalance—Front
6. Pronation—Imbalance—Rear
7. Results Neglected Imbalance
8. Tyloma
9. Acquired Deformity
10. Hammer Toes
11. Bunions
12. Fungus of the Nails
13. Dermatitis
14. Infected Tumors
15. Papilloma—Warts—Verruca
16. Bursitis
17. Circulatory Disorders
18. Eczema from Circulatory Disorders
19. Diabetic Ulcers
20. Neurological Disorders
21. Surgery in Chiropody
22. X-ray in Chiropody
23. Typical Chiropodists Operating Room, Technique, etc.

E—Tape Recordings by Outstanding Authorities (3½″ per second)

"Skin"—R. Montgomery, M.D.—Samuel Peck, M.D.
"Orthopedics"—Dudley Morton, M.D.—H. Weinerman, D.S.C.
"Peripheral Vascular"—John Czarnecki, M.D.—B. Seligman, M.D.
"Diabetic"—Myron Fink, M.D.
"Surgery"—L. Frost, D.S.C.—A. Levin, D.S.C.
"N.A.C. At Work"—W. J. Stickel—L. A. Walsh—M. Shapiro, et al

F—Animated Diagrams "Surgical Approaches to the Bones of the Foot"—(color sound 31 minutes)
These animated diagrams show the anatomy and surgical approaches in various operations on the foot. Must be booked 4 months in advance.

Dr. Marvin W. Shapiro, Chairman
Visual Education Committee
Spitzer Building
Toledo, Ohio

CAPACITY OF REINNERVATED MUSCLES TO FUNCTION EFFICIENTLY AFTER PROLONGED DENERVATION

THE changes which develop in a muscle which has been deprived of its nerve supply are now well known, though several details relating to the processes involved remain obscure. It is generally recognized, however, that prolonged denervation ultimately leads to a condition which is incompatible with the restoration of useful function, even though the muscle has been satisfactorily reinnervated.

It has been ascertained that complete or very good restoration of function can occur in reinnervated human muscles after denervation for at least 12 months as the result of nerve severance, providing that the axons can be directed in sufficient numbers to their original or functionally similar endoneurial tubes and end organs and that the quiescent muscle has been maintained in the best possible condition by appropriate therapy. From this it is concluded that the duration of the denervation and the changes induced in the muscle do not assume significance as regards irreversibility within the first 12 months of denervation.

The most potent factors responsible for the residual defect in muscle function after nerve suture are those which lead to a reduction in the number of functionally effective axons which reach the muscle. Such factors are (a) retrograde neuronal degeneration, which results in a reduction in the number of surviving axons; (b) denervation atrophy of the distal stump and the contained funiculi, which results in the failure of regenerating axons to reach the endoneurial tubes of the distal stump; (c) factors responsible for the erroneous cross shunting of regenerating axons, so that the latter fail to find, enter and descend along appropriate, i.e., corresponding or functionally similar, endoneurial tubes in the distal stump.

Additional factors which may operate below the level of the lesion are (a) changes developing in the muscle as a result of the denervation which may reduce the chances of restoring useful neuromuscular connections or produce a condition in individual muscle fibers which is incompatible with normal functioning after satisfactory reinnervation, and (b) changes in the distal stump which delay or prevent the conversion of axonal pathway into a functionally efficient fiber.

The available evidence, however, suggests that these two factors do not assume significance within the first 12 months of denervation.

Arch. Neurol. & Psychiat. Dec. 1950
S. Sunderland

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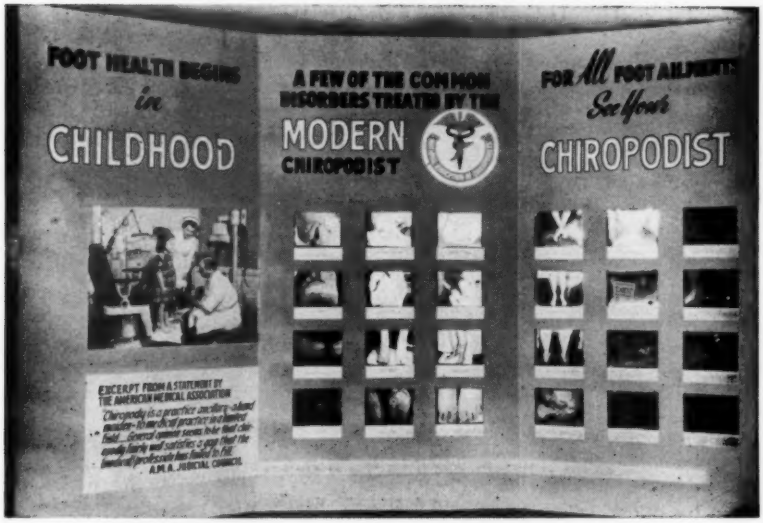

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CHIROPODOLOGIA

In 1768, Dr. D. Low specialized in the care of the feet and practiced on Davies Street, W., London, England. He designated himself a "chiropodist" and in 1774 published a book entitled "Chiropodologia, a Scientific Enquiry, into the cause of Corns, Warts, etc." The volume has been reprinted in serial form because of its historical interest to members of the profession. This is the concluding chapter.

CHAPTER XVII.

OF THE METHODS OF REMEDYING THE ACCIDENTS TO WHICH THE TOE NAILS ARE EXPOSED.

Among the accidents in question, few are more grievous than a swelling and inflammation of the fleshy parts of the toe, from the constant friction or pressure which it sustains from the nail; and in such cases, while we apply to the toe itself a mucilaginous plaster, we must use for the swollen and inflamed part a cataplasm of bread and milk, with the addition of the yolk of an egg, and a little powdered saffron. Wrap it round the whole of the part affected; and, when dry, renew it.

Should a deposit of extravasated blood, or of any other noxious matter, be formed under the nail, we must procure a vent for it as soon as possible; and if this precaution be neglected, we run the risk of deranging its roots, and consequently impeding its future growth. We must then, having bathed the part with a little warm wine, apply a pledget to it, and bind it up. It will soon appear covered over with a crust; but this crust must not be meddled with, and will in due time fall off of itself.

Hildanus relates the cure of an inveterate ulcer on the toe which deserves to be repeated in this place for its singularity, and still more for its importance in teaching us how necessary it is, in every disorder whatever, to know its real cause.

The patient was a young man, a native of Zurich, whose great toe had received a contusion, which was followed, first with a swelling and inflammation, and soon after, with an ulcer, that baffled every effort to heal it. There was also a fleshy excrescence on the toe, larger than a bean, which covered almost one half of the nail. Attempts were made to conquer this excrescence by caustics, till it appeared, that what had been consumed by day, returned in the night like a fungus. Hildanus, in endeavouring to ascertain what it was that thus obstructed the cure, perceived, that the nail was separated from the flesh beneath the excrescence; and that the pain and defluxion were occasioned by its irritation of the sound flesh about the root of the nail. Having discovered the cause, his first steps were, to purge the patient, and to take a little blood from the arm of the side on which the toe was affected. He then put a little of the powder of burned Alum to the excrescence and, in order to mitigate the pain a cooling cataplasm was applied, of which he gives the form as follows:—

Take of Bean flour, two ounces; of the powder of red Roses, of Balaustines, of Cypress-nuts, and of Saffron, two drams each.

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PARTICIPATING CLINICAL SURGERY

This course is offered by the Surgery Department of the Illinois College of Chiropody and Foot Surgery under the supervision of Dr. H. L. DuVries, head of the department.

Registration will be limited to the first ten applicants who are members of the N.A.C. or of the Canadian Association of Chiropodists. Registration will close on July 10, 1954.

The fee for the course will be $200.00. Applications must be accompanied by a $50.00 deposit with checks made payable to the Illinois College of Chiropody and Foot Surgery. Applications should include the name of the school from which the applicant graduated and the year of graduation.

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AND FOOT SURGERY
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Chicago 10, Illinois

Render the whole of a proper consistency with the yolk of an egg, the Oil of Roses, and Rose-water; then apply it warm, not only to the toe, but to the whole foot.

By this treatment, Hildanus adds, the swelling disappeared, and the pain and inflammation ceased. The excrescence also diminished by degrees; and when it had so far abated as to leave uncovered the nail which was detached from the flesh, he exscinded the remainder with a pair of scissors, and a scalpel; applied to the part a desiccative powder; and completed the cure, presently after, with a simple addition of a plaster of Diapalma.

When the toes suffer from the fall of a heavy weight, put the foot into cold water; and then apply to the part a paste composed of acorns, newly gathered, and soap, bruised together, and rendered duly moist with a few drops of Brandy.

When they have sustained a shock in the action of walking or running, or when from any other cause, the laminae, detached from the nails, and rendered superfluous, sprout up with pain in a pyramidal form, the most advisable method is to extract them with a proper instrument.

Of all the accidental complaints to which the feet are liable, this is the most frequent. Ignorant people call it a corn under the nail. It is, in fact, the boast and the triumph of Quacks; and for this reason, that all such corns (if corns they must be called) are easily extracted, and that when extracted, the operator must have been a bungler indeed, if the pain does not cease.

The nails, as I have already mentioned, are renewed, in or about every fourth month. It is to be observed, therefore, that the substances which form these complaints, when detached from the root of the nail, grow beneath it so imperceptibly, that frequently the pain is not felt for two months after the accident happened; and as it is impossible to extract them at the extremity of the nail, without cutting into the quick, so there is a necessity for piercing it at the very spot where the extraneous matter is lodged. This operation, skilfully performed, is not, as it may be supposed, attended with pain; but care must be taken immediately to fill up the aperture, which has been made in the nail, with a little lint dipped in some spirituous liquid.

Upon the whole, I trust that by a due attention to the directions I have above faithfully laid down, my readers may not only be enabled to preserve their nails in a proper form, but to prevent (if not in all cases actually cure) a number of external complaints, which, however slight in appearance, are sure to terminate in very serious consequences, when, from whatever cause, neglected.

The End

WRITING

THE PHYSICIAN should write because writing is one of the disciplines of science, because only by writing can he share his ideas with others, because only by writing can he introduce new ideas and intensify his own knowledge of his subject.

R. de R. Barondes, M.D., Miss. Val. M.J., Sept. 1953.

CHIROPODY EDUCATION

WILLIAM J. STICKEL, D.S.C*

*Executive Secretary, National Association of Chiropodists, Washington, D. C.

CHIROPODY is one of the professions of recent development. Today its practitioners are found in every State and the District of Columbia. More than 300 chiropodists enter the field each year.

Meaning of Chiropody

Chiropody is that specialty of medicine and surgery (an ancillary profession) which is concerned with the care of the human feet, in health and in disease. It consists of the prevention, diagnosis, and treatment of foot disorders by electrical, mechanical, physical, medical, and surgical methods, except amputation of the foot or toes, and includes the non-surgical treatment of the muscles and tendons of the leg governing the functions of the foot.

The terem "chiropody" was first used in 1768 by an Englishman, D. Low, who wrote a treatise entitled "Chiropodologia." A synonym, *podiatry*, common in a few States, came into use in 1917. The words "chiropody" and "podiatry" were derived from two Greek words—cheiro, meaning hand; pous, meaning foot. Originally chiropody was the art of treating diseases of the hands and feet, but today it is confined to treating the feet.

The chiropodist is one of the guardians of public health, and he shares this responsibility with other members of the healing sciences through clinical experience, education, knowledge, skill, and specialization. In treating the lower extremities the chiropodist often finds signs of systemic ailments which are reflected in the feet and legs. Some of these are arthritis, arteriosclerosis, anemia, heart disease, kidney disturbances, and diabetes. The chiropodist is the only practitioner who confines himself exclusively to the care of foot disorders. His practice includes the treatment of skin diseases and infections, shoe therapy, appliance therapy, physical therapy, orthopedic therapy, and surgery.

The Profession

A census of chiropodists completed by the National Association of Chiropodists on January 1, 1953, showed that there were 7,277 licensed practitioners in the United States. Chiropody is one of the least crowded of the professions concerned with maintaining public health. At present there is approximately one chiropodist for every 25,000 persons in the United States. The estimated future need for practitioners is an additional 3,000 by 1958 and 5,000 by 1968. The increased demand for professional foot care arises because more than 70 per cent of the population is afflicted with some type of ailment in the feet.

The practice of chiropody is regulated by law in every State and the District of Columbia. Following graduation from a chiropody college, the graduate is required to take a State board examination to obtain a license. Such examinations are given in the various States by boards of chiropody or medical examiners. Most States also grant reciprocal licenses to practitioners previously licensed by examination in other States.

The official organization of chiropodists, founded in 1912, is the National Association of Chiropodists. Affiliated with it are 49 State societies and several specialty organizations: American College of Foot

Surgeons, American Society of Chiropodical Roentgenology, and the American College of Foot Orthopedists.

The official publication of the profession is the *Journal of the National Association of Chiropodists*, published monthly. Other publications are the *Chiropody Record* and *Current Chiropody*. Many societies issue regional or local journals.

Number of students enrolled in colleges of chiropody in stated years and number graduated[1]

Year ended	Students	Graduates	Year ended	Students	Graduates
1913	161	74	1944	997	366
1915	245	128	1945	1,022	324
1920	342	184	1946	1,069	298
1925	694	364	1947	1,143	281
1930	824	258	1948	1,181	368
1935	864	226	1949	1,204	393
1940	1,166	490	1950	1,096	422
1941	1,288	424	1951	1,087	381
1942	1,225	403	1952	945	329
1943	1,205	419			

[1]In 1913 and 1915 there were three colleges, in 1920, five colleges, and from 1925 there were six.

Evolution of Chiropodical Education

Prior to 1912 chiropodists secured their training through the preceptorship system. In that year the Illinois College of Chiropody and Foot Surgery and the College of Podiatry of Long Island University were founded to teach the basic principles of foot medicine and surgery. The original courses at these institutions were of approximately six months' duration. There are now six recognized colleges in the United States. They have a combined enrollment of nearly 1,000 students, and they graduate annually from 300 to 400. (See the accompanying table.)

All six schools are members of the American Association of Chiropody Colleges, which was organized in 1933.

Accreditation

Chiropody colleges are accredited by the Council on Education of the National Association of Chiropodists, which was created in 1918. This body spent three years in organizing and formulating rules for its guidance. In 1921 the council proceeded to carry out its functions of regulating chiropodical education and making thorough inspections of the chiropody colleges. There are seven members of the Council on Education, all of whom are elected by the House of Delegates of the National Association of Chiropodists. To insure continuity of activity, two members are annually elected for three-year terms. At the annual meeting of this body a chairman is elected.

Over the years the regulations of the council have been periodically revised and elaborated into the essentials for classification in keeping with the progress being made in chiropodical as well as professional

education in general. Among the important objectives of the council are the standardization of preliminary educational requirements and the revision of the basic four-year course. All expenses involved in the operation of the council are borne by the National Association of Chiropodists.

Admission Requirements

The academic requirement for entrance to the colleges of chiropody in 1913 was the completion of two years of high school or the equivalent as indicated by a qualifying certificate issued by appropriate authorities. The requirement was raised in 1930 to graduation from a four-year high school, and in 1940 to the completion of one year of study in an approved college. Currently four of the colleges require one year of college work, the other two require two years. Among the college subjects recommended are chemistry, English, biology, and physics.

Professional Curriculum and Degrees

The course of study in the early colleges of chiropody was of six months' duration. The time was increased to nine months in 1916, to two years in 1921, to three years in 1931, and to four years in 1937. Prior to 1931 some of the colleges gave evening courses.

The course of study advocated by the Council on Education of the National Association of Chiropodists (outlined below) comprises a total of 4,160 hours covering a period of four years. The curriculums in the schools comprise from 4,200 to 4,400 hours of classroom, laboratory, and clinical instruction.

The principal subjects included in the curriculum are: Anatomy, chemistry, bacteriology, physiology, pathology, materia medica and therapeutics, chiropody, foot orthopedics, physical therapy, diagnosis and chiropodical medicine, dermatology, foot gear, surgery, orthopedic surgery, neurology, psychology, hygiene, roentgenology, and clinical practice. Some time is allowed in the curriculum for cultural subjects.

Upon completion of the undergraduate course, the degree doctor of surgical chiropody (D.S.C.) is conferred by five of the colleges; one college confers the degree doctor of podiatry (Pod.D.).

Postcollege Study

All of the colleges provide an elective clinical internship for graduates (a fifth year) in order to meet the requirements of certain State practice acts. Emphasis on all phases of clinical practice characterizes this period of special instruction.

The colleges offer advanced courses to graduate chiropodists. Such instruction includes didactic and clinical training in chiropody surgery, mechanical orthopedics, diagnosis, pediatrics, geriatrics, roentgenology, and physical therapy. Certificates are issued upon completion of such work, but the courses do not lead to degrees.

Current Problems

Education in chiropody is confronted with several important problems. Difficulty in securing competent teachers is a decided handicap. The practice of chiropody offers more lucrative economic returns than teaching and discourages good practitioners from associating themselves with

the colleges. Despite many efforts to attract and retain able teachers, the problems associated with developing teaching staffs and research personnel are now far from solution. Perhaps greater appreciation by the public of better foot care will eventually result in available funds to make chiropodical teaching a more attractive career.

Another problem which is receiving much attention concerns efforts to enroll students who after graduation will be a credit to the profession and contribute to its advancement.

Several programs are now under way to encourage greater interest in chiropodical research. However, here again lack of needed funds is rather discouraging.

Also among the current problems is the provision for a well-balanced education in keeping with the strict requirements of the profession and with the broad cultural background essential to the modern chiropodists.

Schools of Chiropody and Enrollments

The 1953 fall enrollments of the six accredited schools of chiropody are shown by the following data. The first number represents the total, the second the number of women.

CALIFORNIA

California College of Chiropody, 45-1.

ILLINOIS

Chicago College of Chiropody and Pedic Surgery, 82-4; Illinois College of Chiropody and Foot Surgery, 130-3.

NEW YORK

Long Island University College of Podiatry, 158-3.

OHIO

Ohio College of Chiropody, 170-4.

PENNSYLVANIA

Temple University, School of Chiropody, 140-8.

Total enrollment, 725-23.

Selected References

Belleau, W. E. *Chiropody as a Career* Milwaukee, Wis., Park Publishing House, 1952. 27 p.

National Association of Chiropodists. *Chiropody—Vocational Guidance Information.* Washington 10, D. C., The Association, 1953. 4 p.

Council on Education (Harry W. Weinerman, D.S.C., chairman). *Thirty-Third Annual Report.* Washington 10, D. C., The Association, 1952. 23 p.

Reprinted from Higher Education, Vol. X, No. 7, March, 1954, Publication of the U. S. Department of Health, Education, and Welfare.

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American College of Foot Orthopedists—Dr. P. N. Varzos, 25 E. Washington St., Chicago, Ill.

The Journal of the National Association of Chiropodists

Deadline for Journal copy is the 10th of the month before publication (example: copy for June issue should be in our hands by May 10th). The Journal is usually mailed between the 20th and 25th of the month noted on the issue (the June issue is mailed between the 20th and 25th of June).

Orders for reprints must accompany manuscripts. Authors should state quantity desired at the time paper is forwarded to the Journal.

Manuscripts must be typewritten, double spaced, and an original copy must be submitted. Reference should give name and initials of author, volume, page, month and year of publication in the case of periodicals, and publisher and place and year of publication in the case of books. Illustrations must be clear photographs. Glossy prints are preferred. Drawings must be made in black ink on heavy paper or cardboard. Any illustrations should bear the author's name and be numbered in the order in which they are referred to in the text. Illustrations must not be pasted on the manuscript. Legends should be placed on a separate sheet. Tables are not illustrations and should be numbered separately.

PLAN NOW TO ATTEND THIS IMPORTANT MEETING!

What?

42nd Annual Convention of the National Association of Chiropodists —

When?

August 12-17, 1954 —

Where?

Drake Hotel, Chicago, Ill. —

The Drake — Chicago, Ill.

DIABETES MELLITUS IN THE AGED

It is generally believed that there is a basic difference between diabetes mellitus in the older age groups and that in younger persons. The older diabetic's condition is likely to remain stationary or may even require less insulin as time progresses. In other words, they do not appear to demand as close supervision as do younger persons. Also, in older patients the condition develops more insidiously, so that the exact time of onset is not as readily ascertainable as in younger diabetics. It is agreed that a considerable proportion of older diabetics require no insulin and become aglycosuric on diet alone. Further, it is assumed that those who require insulin are the so-called stable type of diabetic who would do well on any kind of insulin and that the majority are on small or moderate doses (under forty units). Certainly, everyone admits that the older diabetic should be treated with extreme caution to avoid vascular accidents.

In order to determine whether diabetes in the aged is actually distinctive and, if so, to define these characteristics more clearly, fifty-nine consecutive case records of diabetic patients in whom diabetes was first discovered after the age of sixty were reviewed. Neurologic signs were present in twenty-nine of the fifty-nine cases studied. The most frequent sign was an absent or greatly diminished achilles tendon reflex. While diabetic neuropathy may occur at any time from childhood to very old age, most authors report the average age of patients with evidence of neuropathy to exceed fifty years and an increasing proportion in each succeeding decade.

Vascular lesions are the most frequent lesions by far which were encountered being present in fifty-seven of the fifty-nine cases. Until recently, it was presumed that arteriosclerosis is a natural concomitant of aging and that an early onset of arteriosclerosis simply implies premature onset of senility. The fallacy of this concept is clearly apparent in diabetics in whom the onset of arteriosclerotic complications are so common at earlier ages.

One of the troublesome manifestations of ischemia in these patients with peripheral atherosclerosis is long, thickened toenails frequently closely adherent to the nailbed. In such patients the feet require very skillful handling. The patients must be cautioned against cutting their own toenails and corns since many of them have poor eyesight and very unsteady hands. The feet should be kept clean by daily washing and dried thoroughly. Tinea infection should be sought and promptly eliminated, avoiding strong irritating local preparations such as salicylic acid or iodine.

Ohio State M. J. 49:981 (Nov.) 1953.

BLUE SHIELD COVERS LIMITED DENTAL CARE IN MINNESOTA

Certain dental treatments, principally those involving oral surgery, are covered in a revised program of benefits available under the Blue Shield insurance plan in Minnesota. The new program, authorized by the state legislature, became effective January 1, 1954. Blue Shield will pay from $15.00 to $75.00 toward the cost of the covered services.

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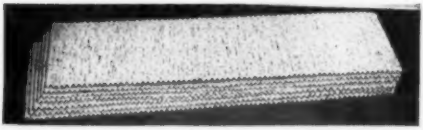

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ABSTRACTS AND HEALTH NEWS

DIABETIC GANGRENE

TRYPTAR, a purified crystalline form of trypsin, rapidly digests necrotic tissue and greatly hastens healing of diabetic lesions. Saul S. Samuels, M.D., of New York City first eliminates infection, which develops in about 90% of cases. Affected areas are incised and drained, if necessary, and Azochloramid is employed. A combination of terramycin and penicillin is particularly effective. When dead and living tissues are clearly demarcated, Tryptar is applied in wet dressings, using 250 mg. in 25 cc. of Sorensen's phosphate buffer solution. The bandage is moistened with freshly prepared solution every three hours. Debridement that formerly took months may now be completed in a week.

Tryptar is manufactured by the Armour Laboratories, Chicago, and has been used extensively to promote early healing of chronic varicose ulcers. In many cases dissolution of necrotic tissue and removal of pus and debris are accomplished within hours with apparently no adverse effect upon living tissue. The product can be used topically in powder form or as a solution with wet dressings.

Angiology 2:589-590, 1951

ATTEND YOUR N.A.C. AND REGIONAL CONVENTIONS

MEDICINE AND RELIGION

WHILE the knowledge of early anatomy had been stimulated by embalming, practised for religious reasons, and by dissections, carried out in the search for omens in the pursuit of magic, the Greek Alcmaeon of Crotona, about 500 B. C., seems to have been among the first to perform, as a scientific observer, dissections and animal experimentation in the search for knowledge of anatomy and physiology. Medicine reached its zenith in the teachings of Hippocrates. Free from superstition, the Hippocratic school recognized in disease a process subject only to the laws of nature, and taught the natural history of disease as it is derived from accurate observation and careful interpretation of symptoms. Treatment was based on the fundamental concept that the healing power of nature was primary and the physician's responsibility was to further nature's ends—an influence which has extended over two millennia.

William A. Rogers, The Background of a Half-Century of Progress, The Journal of Bone and Joint Surgery, November 1950.

ADVANCE FOOT HEALTH WEEK DATES ANNOUNCED BY A.F.H.F.

DR. SIDNEY HIRSCHBERG, President, American Foot Health Foundation, has announced that the dates for Foot Health Week, sponsored by that organization, during the next four years are as follows:

May 13-20, 1955
May 11-18, 1956
May 10-17, 1957
May 9-16, 1958

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KNOWLEDGE

If you can measure that of which you speak, and can express it by a number, you know something of your subject; but if you cannot measure it, your knowledge is meager and unsatisfactory.

Lord Kelvin.

BACTERIAL CONTROL

No single discovery has affected the welfare of man more profoundly than the demonstrations by Pasteur and his associates regarding the cause and spread of disease. The role of individual microorganisms has been laboriously and assiduously worked out and on the results of these researches men have devised methods for the improvement of industries and the protection of man and other animals. The individual methods are varied and complex but the principles on which they are based are the same.

Henry B. Ward, Foreword to Disinfection and Sterilization, by Ernest C. McCulloch, p. 7.

A POINT OF VIEW

Psychosomatic medicine essentially is not a specialty but a point of view, and an approach which applies equally to medical and surgical problems. It is basic medicine which has needed re-emphasis. The compassionate aspect of medicine has perhaps been rather overshadowed by the rapid growth of techniques of investigation and by the present abundance of specific remedies. The best physicians and surgeons have long regarded their patients as individuals with backgrounds which may influence their illness. Some medical men, because they have been too hurried or too poorly trained, may have tended to think only in terms of the immediate disease process and have not had a sympathetic understanding of the patient's problems. There is no doubt that many patients benefit merely from the taking of a detailed history at leisure and in privacy, and the unburdening of their story, often untold to others, may save many weeks of attendances at outpatient departments or surgeries. But "psychosomatic" is an unnecessary term, and the sooner it is dropped from the current literature the better.

—Conn. State Med. J., March, 1952, quoting an Editorial in British Med. J.

BREAKFAST NECESSARY

Omission of breakfast appears to alter the psysiologic responses of men. W. W. Tuttle, M.D., and associates of the University of Iowa, Iowa City, observed 10 men for a six-week period, three weeks on a diet including a basic breakfast, and three weeks with no breakfast. During the period without breakfast, tremor magnitude was increased in 9 of the men and work output was decreased in 8. Choice reaction time was greater in 3, less in 2, and unchanged in the others when breakfast was omitted. A higher incidence of dizziness, nausea, and vomiting indicates that men react more strongly to the omission of breakfast than do women.

J. Am. Dietet. A. 26:332-335, 1950.

HOW TO WRITE BADLY

Some papers may be too short; lengthen them by explaining things that do not need explaining.

The cardinal sin of poor writing is to be concise and simple. A

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cloud of words may conceal defects in observation or analysis. Examples:

Bible: Render to Caesar the things that are Caesar's.

Poor: In the case of Caesar, it might well be considered appropriate from a moral or ethical point of view to render to that potentate all of those goods and materials of whatever character or quality which can be shown to have had their original source in any portion of the domain of the latter.

Concise: The dates of several observations are in doubt.

Poor: It should be mentioned that in the case of several observations there is room for considerable doubt concerning the correctness of the dates on which they were made.

Write hurriedly, preferably when tired. Have no plan. The article will thus be spontaneous and poor.

Paul W. Merrill, in Scientific Monthly 64:72, 1947.

WORTH HEARING AGAIN

THE amateur social doctors are like the amateur physicians – they always begin with the question of remedies, and they go at this without any diagnosis or any knowledge of the anatomy or the physiology of society. They never have any doubt of the efficacy of their remedies. They never take account of any ulterior effects which may be apprehended from the remedy itself. It generally troubles them not a whit that their remedy implies a complete reconstruction of society, or even a reconstruction of human nature. Against all such social quackery the obvious injunction to the quacks is, to mind their own business.

William Graham Sumner, "What Social Classes Owe to Each Other," 1883.

THE SCIENTIFIC GENERALIST

THE complexities of modern society have created the need for scientific generalists. . . . We often hear that "one man can no longer cover a broad enough field" and that "there is too much narrow specialization." . . . At all levels, decisions must be made which involve considerations of more than a single field. These difficulties are most pressing in the borderline fields like physical chemistry, chemical physics, biophysics, high polymers, and the application of chemistry, physics, and mathematics to medicine. . . . We need a simpler, more unified approach to scientific problems, we need men who can practice science – not a particular science–in a word, we need scientific generalists. . . . The generalist would naturally be concerned with system problems. These problems arise whenever parts are made into an integrated whole.

Science, 109:553, 1949.

THE BEAUTIES OF LEARNING

THE person who quits learning upon leaving university or school is giving in to an idea of limited usefulness, limited satisfaction and limited happiness. He is contributing to his own bewilderment and feeling of insecurity in a fast-moving world. Continuing education qualifies us to bring relevant background to bear upon current problems, to gather information pertinent to the question in hand, to grasp relationships between this state of affairs and another, between this person's action and his social environment; and–this is the aim and object of it all–to make a judgment in the light of clearly defined values and our information.

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It is not in terms of years that maturity is to be measured, nor yet in terms of knowledge. To be mature is to use knowledge wisely. The mature person has learned and is learning; he has experienced and is daily taking note of his experiences; he has achieved the ability to weld these two, knowledge and experience, in his own mind and to produce judgments and plans.

HOW TO IMPROVE YOUR THINKING

THE best way to begin to improve your thinking is to resolve to think more effectively. To do this is to recognize that the closed mind is the greatest single drawback to good thinking.

How can we recognize the good thinker? First, he has a flexible mind. Many potential thinkers are handicapped by laziness, fixed habits and satisfaction with the status quo. The good thinker is also a hard worker. Thinking involves a complicated process including the location of the difficulty, collection of pertinent data, the reasoned analysis of facts and inferences, shrewd deductions of the most promising solutions until the right one presents itself, suspended judgment, and continuous evaluation. Third, the good thinker is self-disciplined. He learns to set aside emotion in favor of reason. Anger, love, fear, and hate add color to our lives but are serious drawbacks to good thinking. Finally, the good thinker has courage. It is not always easy to come up with an answer that is unfavored by the group, even though it is the correct answer.

Advanced Management, Jan., 1954.

SPEECH AND CIVILIZATION

EFFECTIVE comparison and contrast are the basis for description and enumeration and the measure of intelligence. Some philologists and ethologists have said, in effect, that all known human languages, either directly or by circumlocution, can contrast me and you, here and there, inside and outside, now and then, today and tomorrow, mother and offspring, "father" (in different senses), friends and enemies, and so on for untold thousands of ideas. By means of this immeasurably potent apparatus of articulate speech man collectively has transformed himself and created many worlds: such as codes of behavior, civilizations, philosophies, mythologies, religions, sciences, inventions, systems of education, the fine arts, the game of chess and thousands of others. But it is no wonder that to the man on the street the idea that man could develop out of any kind of speechless ape might seem merely funny. Not a few philosophers and mathematicians, with no real knowledge of the evidence that they themselves and their systems are by-products of the "procession of the vertebrates," have been inclined to set man on a lonely pedestal and to treat such a naively human personification as "mind" as if it were truly an objective individual entity instead of an artificial summation for billions of different psychosomatic responses by human and other sentient beings.

William King Gregory, "Evolution Emerging," 1951, Vol. 1, p. 538.

VIROLOGY

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dimension — and are capable of growth only within the substance of living cells of a susceptible host. Virology as a science can be regarded essentially as the unfolding of the implications of that definition. . . . The influenza virus enters the cell by undergoing specific absorption to muco-protein molecules that form a meshwork over the free surface of the respiratory epithelium or other type of susceptible cell. The virus carries on its surface certain molecular groupings which attach to complementary grouping on the muco-protein. Once firmly attached, the virus particle sinks into the cytoplasm. . . .

To understand what happens when the virus particle enters the cell, we have to think of its structure in a different way from the chemical approach we adopted previously. You remember the nineteenth century differentiation of the germplasm from the soma, and the paradox that the essential continuing part of a species was the genetic mechanism carried in the germ cells, and that the body, the soma, was to be thought of merely as the machinery needed to protect, to nourish and to pass on the genetic pattern. In much the same way one can think of a virus particle as composed of somatic and genetic parts, the soma and the genome. The surface characters of the virus, its immunological nature, its adsorptive, haemagglutinating and enzyme-like activities are somatic, and they are the only static qualities by which the existence of virus can be recognized. The genome has as yet no detectable qualities by which its presence can be recognized, short of testing the power of the virus to multiply. . . . The virus becomes undetectable soon after it enters the cell, and we must assume that somatic material disintegrates and plays no further part in the process. On the basis of what has been found out about bacterial viruses, the genetic material is presumed to be the only part of the virus particle that initiates the process of multiplication.

Virus genetics is a very new subject, and to date the only published work on the experimental study of influenza virus genetics comes from the Walter and Eliza Hall Institute. The rest of the world has as yet expressed no opinion; but I am hopeful that the development of methods for studying the genetics of viruses pathogenic for animals may come to be regarded as the most important contribution the institute has made to microbiology.

Med. J. Australia, Dec. 5, 1953.

ORGANIZATION NEWS

SURGERY POST GRADUATE COURSE OFFERED BY ILLINOIS COLLEGE

THE Third Annual Post Graduate Surgery Course will be offered at the Illinois College of Chiropody and Foot Surgery, August 18 through 22, 1954. The course will be under the supervision of Dr. H. L. DuVries, head of the Surgery Department at Illinois College of Chiropody. The staff and schedule will be announced in the near future.

The major portion of the course will consist of student participation in cadaver and clinical surgery.

The registration will be limited to the first ten applicants who are members of the National Association of Chiropodists or Canadian Association of Chiropodists. The registration will be limited to a maximum of ten and will be of-

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fered to a minimum of eight. The registration will close on July 10, 1954.

The fee for the course will be $200.00. Applications must include a $50.00 deposit, with checks made payable to the Illinois College of Chiropody and Foot Surgery. Applications should include the name of the school from which the applicant graduated and the year of graduation.

Recently a post graduate Seminar in Advanced Orthopedic Techniques was completed. The course was given under the direction of Dr. A. Rubin. Some of the subjects covered were: Case Analysis and Evaluation, Acrylic Resin Techniques, Intra-articular Injection Therapy, Melamein Resin Treated Plaster of Paris Casting, and Office Modification and Prescribing of Plantar Appliances.

PEDIC RESEARCH SOCIETY TO GIVE POST GRADUATE COURSE

THE Fellows Pedic Research Society has tentatively scheduled a post graduate course to be given October 21-24, 1954, at the Illinois College of Chiropody. Arrangements for an excellent staff of lecturers are being made.

OHIO

Eastern Division

A MEETING of the Ohio Eastern Academy of Chiropody was held in Salem, April 4, 1954. The following officers were elected: President, Dr. W. L. Beylin; Vice President, Dr. S. M. Moore; Secretary-Treas., Dr. E. E. Dolges.

Mahoning Valley Division

THE Mahoning Valley Chiropody Association met recently in Struthers, Ohio. Plans for continuing the examination of school children were made and the group outlined a foot health week program. The following officers were elected: President, Dr. E. Weaver; Secretary, Dr. S. Pusateri; Treasurer, Dr. G. Nicolette. Dr. S. Cosentino was selected as chairman of Foot Health.

MICHIGAN

THE Northeastern Division of the Michigan Chiropody Association held a regular meeting March 28, 1954 in Saginaw. Several members of the group read scientific papers.

OKLAHOMA

THE annual meeting of the Oklahoma Chiropody Association was held April 11, 1954, in Shawnee. The following officers were elected:

President, Dr. A. D. Conley

President-Elect, Dr. H. R. Johnson

Vice President, Dr. W. C. Bonnell

Vice President, Dr. F. M. Hatcher

Secretary, Dr. C. Parham

Treasurer, Dr. M. H. Gennis

ALABAMA

THE annual meeting of the Alabama Association of Chiropodists was held March 21, 1954. The following officers were elected:

President, Dr. John Cooper

Vice President, Dr. T. H. LeCroy

Secretary-Treasurer, Dr. Elizabeth S. Austin

Chairman, Board of Trustees, Dr. W. J. Aucoin

Member, Board of Trustees, Dr. G. B. Crowley

N.A.C. Delegate, Dr. Edward E. Sealy

Elected to the State Board of Examiners were: Drs. Elizabeth S. Austin, W. J. Aucoin and T. H. LeCroy

TEXAS

THE Chiropody Society of Texas held its annual meeting in the Shamrock Hotel, Houston, May 14-16, 1954. Dr. Harry Lipscomb, Resident Pathologist of the M. D. Anderson Hospital for Cancer Research, University of Texas, lectured on "Malignancies of the Lower Extremities." Dr. Lewis M. Hoppock, a past president of the Texas Society and staff chiropodist at the Scott and White Clinic, Temple, Texas, spoke on "Mechanical Corrections of Foot Imbalance." The group toured the new hundred million dollar Texas Medical Center and made a boat trip to the San Jacinto Monument.

PENNSYLVANIA

Lehigh Valley Division

AT a recent meeting of the Lehigh Division of the Chiropody Society of Pennsylvania, the following officers were elected: President, Dr. Ned Enea; Vice President, Dr. Norman Reiter; Secretary-Treasurer, Dr. R. H. Shaw. Following the election, the group met with the Clinical Society of the Lehigh Valley Diabetes Association, where Dr. George Anderson was the principal speaker.

Western Division

THE Western Division of the Chiropody Society of Pennsylvania held a scientific meeting March 28, 1954 in Pittsburgh. Approximately 200 members were present from Pennsylvania and surrounding states. The following scientific program was presented: "Practical Dermatology," W. B. Ignatoff, D.S.C., Newark, N. J.; "Peripheral Vascular Diseases," Harry I. Miller, M. D., University of Pittsburgh; "Roentgenology," R. Dickson, D.S.C., Ellwood City, Pa.; and "Drugs Used in Chiropody," Chester L. Rossi, D.S.C., Du Bois, Pa.

The Division also met in Pittsburgh on April 8, 1954 and Dr. C. Dana Bossart lectured on "Visual Evaluation in Podo-Pediatrics." Nominations for officers were presented at this meeting.

FLORIDA STATE BOARD DATES

THE next examinations given by the Florida State Board of Chiropody Examiners will be held at the Orange Blossom Hotel in Sarasota, June 14, 1954. Applications must be filed with Dr. Heywood A. Dowling, Secretary-Treasurer, 203 Greenleaf Building, Jacksonville 2, Fla.

MINNESOTA STATE BOARD DATES

THE Minnesota State Board of Chiropody Examiners and Registration will give their annual examination at the Minnesota State Capitol in St. Paul on June 17, 1954. For information write to Dr. Howard E. Hedman, 366 Bremer Arcade, St. Paul, Minn.

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PHI ALPHA CHI SORORITY MEETS

THE Phi Alpha Chi Sorority held a meeting March 20, 1954 in honor of Dr. Agnes Reiling of Chicago, who is retiring after being in practice for 36 years. Dr. Reiling graduated from the Illinois College of Chiropody in 1919 and has been an active member of the Illinois Association for 36 years. Dr. Anna Slain presented her with an engraved pen and pencil set on behalf of the Sorority.

CONNECTICUT

THE Connecticut Chiropody Society held its annual scientific symposium in New Haven at the Medical Association Library on May 23, 1954.

WOMEN'S AUXILIARY

MAY is the month to pay your National Auxiliary dues. The amount is $1.00. If your local treasurer has not reminded you, please send in your dues or send a check to Mrs. Miriam Shor, 5389 Kalein Drive, Culver City, Calif.

It is an inspiration to hear all the ways our auxiliaries find to bring Chiropody to the attention of the public. Those are the kind of reports that make our enthusiasm burst out at the the seams.

The Salt Lake City Auxiliary has been very active. Their book review and bake sale brought in enough cash to enable them to substitute for Santa and supply necessities for a family of six at Christmas; their Easter party complete with dolls, stuffed animals and clowns made by the women brought many a smile to the faces of children in the Salt Lake County Hospital. The Auxiliary works at this hospital with the chiropodists who

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donate their services to the children. Mrs. S. L. Hansen was installed as President of this Auxiliary. She will be assisted by Mrs. G. R. Leonard, Vice President; Mrs. W. Truman Rigby, Secretary; Mrs. S. L. Stoker, Historian; and Mrs. Eugene R. Strong, Publicity. This group has done an outstanding job in its organization year and conducted a splendid Foot Health Week program in Salt Lake City.

Ethel Douglas, of the Southern California Division, added $10.00 to our "talent" fund and earned it doing extra jobs in her husband's office. Miriam Aronow and Miriam Shor of Los Angeles used a "Name Your Game" party as their "talent" event. A chuck wagon dinner set up in cabaret style was a big hit. Every game from roulette to scrabble was played. That party added $40.00 to the fund.

The officers of the new San Diego Auxiliary are Patricia Eads, President; Helen Maize, Vice President; and Marilyn Papier, Secretary. This group has fifteen members and already earned $11.00 for the "talent" fund at a card and bingo party held at the home of Dr. and Mrs. Fipps.

Bernice Greiner, of Columbus, Ohio, proves that all slot machines are not one-armed bandits. On a visit to Nevada, Bernice and Dr. Greiner attempted to convince their three young Greiners that gambling does not pay. Imagine the ineffectiveness of that lesson when Bernice invested her "talent" and eighteen silver dollars poured out of the slot machine. Maybe the lesson was not too effective, but the "talent" fund is grateful.

Dorothy Hatfield, of Waukesha, Wis., has made, donated and sold nylon corsages and rick-rack earrings and her $10.00 has been received. Clever invitations to a box supper at the home of Dr. and Mrs. Earl G. Buske in Milwaukee

brought out a good crowd and the auctioning of the boxes was a lot of fun. A soft drink stand, special games of skill and other attractions on the mid-way added to the cash-box total.

Mrs. Vera Pearce, President of the Missouri Auxiliary, answers our questionnaire with very constructive criticism and good suggestions. She reports the St. Louis women are busy with plans for a "hobo" party as their "talent" affair. Two individual members in St. Louis have made friendship aprons, charging friends to autograph them—clever idea—and one member has already taken in $17.00 with her apron; another member is wrapping and selling her "white elephants"; another has movie night of home movies with admission charges, soft drink concession, etc.; another is making a ming tree to raffle. The Kansas City Auxiliary members get together when their men meet and serve a dollar lunch. That is fun and profit combined.

The Texas Auxiliary met May 14-16, 1954 at the Shamrock Hotel in Houston. A very interesting lecture on cancer attracted many of the women, followed by a luncheon in the Emerald Room. A boat trip down Houston's busy ship channel to San Jacinto Monument, the Battleship Texas and a seafood dinner at San Jacinto Inn filled one day. The "talent" greenback tea at the home of Mrs. L. K. Bunch gave Texas another brag.

Mrs. C. J. Wyek, 2853 Rockwood Place, Toledo, Ohio, has been appointed Chairman of the Nominating Committee to make up a slate of nominees for presentation in Chicago. She will be interested to have your suggestions.

Margaret Dobbs, President
N.A.C. Women's Auxiliary

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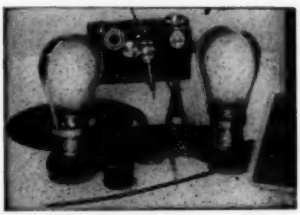

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MISSOURI ASSOCIATION OF CHIROPODISTS
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REGION ONE
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DEATHS REPORTED

Dr. Edwin A. Craw
Oakland, Calif.

Dr. E. R. Cronlund
Bryn Athyn, Pa.

Dr. E. R. Cronlund passed away on January 19, 1954, in his 78th year. He graduated from Temple University in 1922 and served for a number of years on the Clinical Staff of the Chiropody School.

Dr. Wallace G. Greenwell
Ogden, Utah

Dr. Wallace G. Greenwell, age 48, of Ogden, Utah, passed away recently after a short illness. He was active in the Ogden Community Theater, a member of the B.P.O.E., and the Executive Club. Dr. Greenwell was also active in Boy Scout work and he was a member of the LDS, Mount Ogden Ward. He graduated from the Illinois College of Chiropody in 1927.

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DIFFERENT . . . Unlike soap and soap-substitutes, it contains no alkali or chemical detergents.

. . . Made with AVEENO COLLOIDAL OATMEAL

Indications: To replace soap and soap-substitutes where these may irritate the skin or aggravate eczemas, rashes, poison ivy and other dermatoses.

Available in 3 oz. shaker-top cans

Professional samples available upon request

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